

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14262 Item 9 Film G304 1/2/62 iwk 14232											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY Prince Georges				e. STATE Maryland				b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b 12 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 118 69th St.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James T Adams				4. DATE OF DEATH Month Day Year Dec 25 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 March 1886 7578		9. AGE (In years last birthday) yrs. Months Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Saint Joe, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JAMES T. ADAMS				14. MOTHER'S MAIDEN NAME ELIZA TURNEY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no				16. SOCIAL SECURITY NO. 509-18-7485				17. INFORMANT JAMES G. ADAMS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the prostate gland DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 3:25AM from the causes and on the date stated above. 22a. SIGNATURE Gordon W. Kelley M.D. 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec 28, 1961 23c. NAME OF CEMETERY OR CREMATORY Washington National 23d. LOCATION (City, town or county) (State) Suitland Md. 24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517-11th St. S.E. 25a. REC'D BY REGISTRAR DATE DEC 28 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

1932

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James T. Adams
1932-1933 James T. Adams

James T. Adams

James T. Adams
1932-1933 James T. Adams

16
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 0302

14233

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia		b. COUNTY 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ritchie Extension of 86 th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3001 Nelson Place, S.E.		4. DATE OF DEATH Month December Day 6th. Year 19 61		9. AGE (in years last birthday) 58 yrs.	
3. NAME OF DECEASED (Type or print) John Leo Alcorn		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1903	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY U.S. Printing		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		14. MOTHER'S MAIDEN NAME Anna Downs	
13. FATHER'S NAME John Alcorn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Reginia A. Alcorn		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gun shot wound of the head DUE TO (c) Gun shot wound of the head									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head while sitting in a Porche Car							
20c. TIME OF INJURY Month, Day, Year 7:50 P.M. 12-6 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Port Hagerman		20f. (City or town) Industrial Park Pk. Md		20g. (County) Prince George's	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) Southland Md		(State)	
23. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661 Wood Ave Rd SE WASH DC		24a. REC'D BY REGISTRAR DEC 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. House		DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14264

14234

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Bladensburg</u> d. STREET ADDRESS <u>5416 Spring Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Viola Bell Anderson</u>				4. DATE OF DEATH Month Day Year <u>December 27, 19 61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 7, 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniels</u>				14. MOTHER'S MAIDEN NAME <u>Jane Wells</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Viola B. Jarboe 5614 Quincy St. Hyatts., Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> (b) <u>Coronary Thrombosis</u> (c) <u>Hypertensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>4 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 26</u> , 19 <u>61</u> , to <u>Dec 27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 27</u> , 19 <u>61</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Norman D. Comeau</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>December 27, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>Norman D. Comeau, M.D.</u>				22d. ADDRESS <u>3503 Perry Street, Mt. Rainier, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Basch's Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Hyattsville</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO H.C. 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

14303

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Houseswife

Own House

Washington D.C.

U.S.

Daniel

Jane Wells

None

Violin D. L. Woods & Sons

Hunter & Lamm

Germany

Wentworth & Co.

1942

1942

Signature

Cedar Hill

Seaside

Local & ...

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14235

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 Hillside			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 6206 L Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6206 L Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Oliver Barrett				4. DATE OF DEATH December 29, 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1901	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Washington Barrett				14. MOTHER'S MAIDEN NAME Susan Virginia Florence			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-0340646			
17. INFORMANT Mrs. Martha Barrett, Capital Heights, Md				Address 429 50th Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 12/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JAN 2, 1962		22c. NAME OF CEMETERY OR CREMATORY ADDISON CHAPEL		22d. LOCATION (City, town, or country) (State) SEAT PLEASANT, MD	
23. FUNERAL DIRECTOR W. W. Chamber Co				24a. REC'D BY REGISTRAR Arthur S. Hines			
24b. REGISTRAR'S SIGNATURE				DATE JAN 4 '62			

MEDICAL CERTIFICATION

333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14266

14236

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1614 N. J. Ave., N. W., Apt 2			
3. NAME OF DECEASED (Type or print) First Middle Last Shelton B. Benton				4. DATE OF DEATH Month Day Year 12 21 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (retired)		10b. KIND OF BUSINESS OR INDUSTRY Pullman Company Union Station		11. BIRTHPLACE (County & State, or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Coleman Benton				14. MOTHER'S MAIDEN NAME Mathilda Cottie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 709-12-4545		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with cardiomegaly 420-0 DUE TO and left heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized atherosclerosis; chronic pyelonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/20 1861, to 12/21 1961, that (I) (we) last saw the deceased alive on 12/21 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/21/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) bu.		23b. DATE THEREOF 28/61		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) Hickory N.C.	
24 FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS 1435 Md ave NW		25a. REC'D BY REGISTRAR DEC 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

14380

CLASSIFICATION OF DATA

14380



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14267

Item 4 Film 0303

12/27/61 mh

14237

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 Hrs		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 3302 Bellevue Avenue		d. STREET ADDRESS 1 Cheverly		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last William Olin Bobb		4. DATE OF DEATH Month Day Year December 19, 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1878		9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Bobb		14. MOTHER'S MAIDEN NAME Mary Houzeal		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Karl F. Bobb		Address Same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractured skull (c), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.) Fell down stairs at home																	
20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. 12/18/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cheverly		(County) P.G.		(State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/20/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or country) Rockville, Md.		23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DEC 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris					

14207

Nov. 11, 1918

Dear Sir,

I have

been

very busy lately

and have not had time to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14268

CERTIFICATE OF DEATH

11238

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 8 months and 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
4. DATE OF DEATH First Middle Last Alice - Bocsein		6. DATE OF DEATH Month Day Year 12 1 19 61	
5. SEX Female		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. COLOR OR RACE White		9. AGE (In years last birthday) 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (unknown)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Bocsein		14. MOTHER'S MAIDEN NAME Ottillie Heinzlar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No -		16. SOCIAL SECURITY NO. None	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Thrombophlebitis, left leg DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis; coronary atherosclerosis; hiatal hernia with chronic ulceration; mid-thigh amputation, right leg.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/22/12-11-60 to 12/1/1961 , that (I) (we) last saw the deceased alive on 12/1/1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.		22a. SIGNATURE Moe Weiss M.D. 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
22b. DATE SIGNED 12/1/1961		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-5-61	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Washington D.C.		25a. REC'D BY REGISTRAR DEC 6 '61	
25b. REGISTRAR'S SIGNATURE William S. Thomas			

2000

2324

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 1, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. recurrent abdominal abscesses, right lower lung field, etiology undetermined; staphylococcus aureus; pneumonia; pneumonitis; etiology undetermined; resolved; exfoliative dermatitis; etiology undetermined; arthralgias, 1/60 and 1/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14269

14239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY in 1b 8 months and 17 days		d. STREET ADDRESS 414 Eye St., N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Atchie J. Bolden		4. DATE OF DEATH Month Day Year 12 4 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/22
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
11. BIRTHPLACE (County & State, or foreign country) N.S.A., Fort Meade, Md. Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Justice		14. MOTHER'S MAIDEN NAME Adeline Rickman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown -		16. SOCIAL SECURITY NO. Unknown (lost)	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to staphylococcus aureus DUE TO (b) Staphylococcus aureus infection of pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undifferentiated collagen vascular disease; cirrhosis of liver; subtotal thyroidectomy, 1942 & 1960; secondary hypoparathyroidism; chronic pyelo*		INTERVAL BETWEEN ONSET AND DEATH Unknown Approximately 20 months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/17/12:47 to 12/4/19.61 that (I) (we) last saw the deceased alive on 12/4/19.61, and that death occurred at 12:47 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/4/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-7-61		23b. DATE THEREOF KENTUCKY	
23c. NAME OF CEMETERY OR CREMATORY PRESTONBURG		23d. LOCATION (City, town or county) (State) KENTUCKY	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

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Unknown

See also: Harold M. Brown, and see

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Continued, and will be continued

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be designed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14271

CERTIFICATE OF DEATH

Reg. Dist. No.

14241

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Forestville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8001 Marion St.		d. STREET ADDRESS 8001 Marion St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Doc S. BRADLEY		4. DATE OF DEATH Month Day Year DEC 24 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Bradley		14. MOTHER'S MAIDEN NAME Martha Wheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-03-1700	
17. INFORMANT Minnie L. Bradley		Address Same #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Bronchopneumonia DUE TO (b) Carcinoma of esophagus with Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days 8 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1961, to Dec 24, 1961, that I last saw the deceased alive on Dec 23, 1961, and that death occurred at 3:20 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest E. Cornelsen M.D.		ADDRESS (Street, city or town, state) 4400 Brown Rd SE WIL 9	
DATE SIGNED 12/24/61			
PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 Dec. 1961	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. D.C.		ADDRESS Wash.	
24a. REC'D BY REGISTRAR DATE DEC 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

THE FRONTIER—HOW TO ENTER BO STATE CLAIMS

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
14272
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3905 Newark Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle R. Last Bragg		4. DATE OF DEATH Month Dec. Day 19, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1893
9. AGE (In years lost birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government		10b. KIND OF BUSINESS OR INDUSTRY Unemp. Comp. Bureau - Virginia	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Bragg		14. MOTHER'S MAIDEN NAME Burnie Farrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 1		16. SOCIAL SECURITY NO. Harold E. Supplee Same as #2 (Brother in law)	
17. INFORMANT Harold E. Supplee Same as #2 (Brother in law)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Mems. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic artery disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-29 19 61 , to 12-19 19 61 , that (I) (we) last saw the deceased alive on 12-19 19 61 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George J. Hageage		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) George J. Hageage		22d. ADDRESS 3717 38th Ave. Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25. REC'D BY REGISTRAR DEC 26 '61	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE William S. Kneass	

1937

CERTIFICATE OF DEATH

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DATE OF DEATH

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PLACE OF DEATH

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James I. Ford, M.D.

James I. Ford, M.D.

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

24 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14244											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Camp Springs</u>				d. STREET ADDRESS <u>5380 Auth Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5380 Auth Road</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Lydell Sarah Brown</u>						4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Rothenberger</u>						14. MOTHER'S MAIDEN NAME <u>Cora Bell McCarmon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>one at 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Dec 30, 1961</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/3/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or country) <u>Suitland, Md.</u>		(State)	
23. FUNERAL DIRECTOR ADDRESS <u>Francis Gasch's Sons Hyattsville, Maryland</u>						24a. REC'D BY REGISTRAR <u>JAN 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

1937

1937



Francis Cason's Son
1937

Francis Cason's Son
1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14275

CERTIFICATE OF DEATH

14245

1. PLACE OF DEATH e. COUNTY Prince Georges f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 38 O. St., S. W. d. STREET ADDRESS 38 O. St., S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry First Butler Last		4. DATE OF DEATH Month 12 Day 21 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1911
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months — Days —	11. IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Butler		14. MOTHER'S MAIDEN NAME Mary Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Lost (Unknown)	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus with esophago-tracheal fistula DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Gastrostomy, 4/61		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/22/1961 to 12/21/1961 , that (I) (we) last saw the deceased alive on 12/21/1961 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss M.D.		22b. DATE 12/21/1961	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 12-26-61	
23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION (City, town or county) (State) Open Hill Sm.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. ADDRESS 3015-12th St. N.E. D.C.		25a. REC'D BY REGISTRAR DEC 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Rhines			

14372

TEMPERATURE OF CLIMATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14276 Items 8 & 9 Film G304 1/2/62 iwk 14246											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE md f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 06 Lanham g. STREET ADDRESS 16706 Auburn Ave h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MINNIE FRISTOE BYWATERS						4. DATE OF DEATH DEC 20 1961					
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1871		9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Va.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Scott Fristoe				14. MOTHER'S MAIDEN NAME Mary Presgraves			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —				17. INFORMANT Earl M. Bywaters Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) GENERALIZED ARTERIOSCLEROSIS (c) 10 years cause last, (c) 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DECUBITUS ULCER											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1956 to Dec 1961 , that (I) () last saw the deceased alive on 19 Dec 1961 , and that death occurred 8:45 M, from the causes and on the date stated above.											
22a. SIGNATURE Thomas G. Maloney M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 20 Dec 61		
22c. PHYSICIAN'S NAME (Type) HOMAS G. MALONEY						22d. ADDRESS 4814-71st Ave. Lanham, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		12/23/61		Beans Cemetery		Luray		VA			
24. FUNERAL DIRECTOR'S SIGNATURE Gasche sons Hyattsville Md						25a. REC'D BY REGISTRAR DEC 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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St. Louis

Scott's

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Mr. H. H. H.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14277

14247

1. PLACE OF DEATH o. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>9108 Drake Place</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>JAY</i> Middle <i>HAROLD</i> Last <i>CARNS</i>				4. DATE OF DEATH Month <i>12</i> Day <i>19</i> Year <i>1961</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 17, 1884</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months <i>12</i> Days <i>19</i>	IF UNDER 24 HRS. Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Robert Carns</i>				14. MOTHER'S MAIDEN NAME <i>Ada Listerbarger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>482-10-7063</i>		17. INFORMANT <i>Harry Carns</i> Address <i>9108 Drake Pl., College Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Nephrosclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Interval between onset and death 8 months</i> (b) <i>unknown</i> (c) <i>10 years</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>6-5-1961</i> to <i>12-19-1961</i> , that (I) (we) lost saw the deceased alive on <i>12-18-1961</i> , and that death occurred at <i>12:30</i> M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Eino Magi</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>12-19-61</i>							
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i> 22d. ADDRESS <i>918 University Blvd. E., Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Dec 22-1961</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Ingwood Park</i>				23d. LOCATION (City, town or county) (State) <i>Ingwood California</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Kellers</i> ADDRESS <i>254 Carroll St.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 21 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kellers</i>							

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REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1901

ALBANY:
J. B. LEECH, PRINTER.
1901.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14278

CERTIFICATE OF DEATH

14248

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY PG		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS Box 148 Rt 1 Contee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Louise		4. DATE OF DEATH Month 12 Day 20 Year 1961		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1/20/05		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 12 Days 20 Hours 19 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Thomas		14. MOTHER'S MAIDEN NAME Maggie Jackson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —							
17. INFORMANT Roosevelt Castle		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Fibrosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction, recent DUE TO (c) Hypertensive Coronary Arteriosclerotic Ht. Disease		INTERVAL BETWEEN ONSET AND DEATH 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis, severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/16 , 1961 to 12/20 , 1961, that (I) (we) last saw the deceased alive on 12/20 , 1961, and that death occurred at 7:20 PM from the causes and on the date stated above.		22a. SIGNATURE Gordon W. Kelley		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. (City or town) (County) (State)		22g. (City or town) (County) (State)							
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-24-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Queens Chapel		23d. LOCATION (City, town or county) (State) Murkbk Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. ADDRESS 4925 Neome Ave							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11-10-18

11-10-18

At Home
1/10/18

Joseph Thomas
At Home

Joseph Thomas

Joseph Thomas

Joseph Thomas

Joseph Thomas

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Joseph Thomas

Joseph Thomas

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14249											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Huntsville					
c. LENGTH OF STAY IN 1b D.C.A.						d. STREET ADDRESS N Street					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANGENETTE JOY CHASE						4. DATE OF DEATH December 27, 1961					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1961		9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome Elwood Chase						14. MOTHER'S MAIDEN NAME Alfreda Elizabeth Harrod					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alfreda E. CHASE,		Address N Street Huntsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James D. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12/27/61		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-30-61				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Nat Harmony		22d. LOCATION (City, town, or county) (State) Highland Pk Md			
23. FUNERAL DIRECTOR Lenny Washington & Sons 4925 Deane Ave N.E.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
DATE JAN 2 '62						Arthur S. Kraus					

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(12)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14280											
CERTIFICATE OF DEATH											
Item 9 Film G305 1/8/62											
1. PLACE OF DEATH a. COUNTY		Prince Georges.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY in 1b 8 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		74 Beltsville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prince Georges General Hospital		d. STREET ADDRESS		11012 Montgomery Rd.					
3. NAME OF DECEASED (Type or print)		First James		Middle ROBERT		Last Cocker		4. DATE OF DEATH		Month Dec. 31 19 61	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
								15 Nov. 1883		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		Buyer Clerk, None		10b. KIND OF BUSINESS OR INDUSTRY		Left Store		11. BIRTHPLACE (County & State, or foreign country)		Washington, D. C.	
13. FATHER'S NAME		Henry Cocker		14. MOTHER'S MAIDEN NAME		Catherine Ryan		12. CITIZEN OF WHAT COUNTRY?		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		no		16. SOCIAL SECURITY NO.		577-01-3081		17. INFORMANT		Address 801 Bayfield St. Joking B. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction (c) acute pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		12-23-61 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-23-61 to 12-31-61 that (I) (we) last saw the deceased alive on 12-31-61 and that death occurred at 11:30 PM from the causes and on the date stated above.											
22a. SIGNATURE IRVIN M. GRASSGREEN, M.D.				22b. DATE SIGNED 1-1-62		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS MT. RAINIER, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF 1-3-1962		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town or county)		Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Chambers & Co				25a. REC'D BY REGISTRAR DATE JAN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

10320

(M)

(1)

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14281

CERTIFICATE OF DEATH

Reg. Dist. No. 14251

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland			
c. LENGTH OF STAY IN 1b 1 Day				d. STREET ADDRESS 4417 Ferndale Pl.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews AFB				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTHER Middle BARRETT Last COX				4. DATE OF DEATH Month December Day 24 Year 1961			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1921	
9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
13. FATHER'S NAME William Lee Garrett				14. MOTHER'S MAIDEN NAME Olive Francis Baldwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1943 to 1944				16. SOCIAL SECURITY NO. None			
17. INFORMANT James L. Cox				Address 4417 Ferndale Pl., Oxon Hill, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA of UTERUS with metastases 174X DUE TO (b) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 9 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. , 19 61 , to Dec 24 , 19 61 , that I last saw the deceased alive on Dec 24 , 19 61 , and that death occurred at 1310 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews AFB DATE SIGNED 24 Dec 1961							
ACTUAL SIGNATURE James M. Finneran				M.D. USAF Hospital Andrews AFB			
PHYSICIAN'S NAME (Type) James M. Finneran							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Dec 27-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros				24a. REC'D BY REGISTRAR DEC 27 61			
ADDRESS 1661-44 Hope Rd & E				24b. REGISTRAR'S SIGNATURE Arthur E. Finneran			

James L.

...

...

February 2, 1901

Virginia

Five

James L.

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

14282 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14252

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Mass. Middlesex		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynnfield 58x-3		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital			e. STREET ADDRESS 68 Crescent Ave.		
3. NAME OF DECEASED (Type or print) MILDRED			4. DATE OF DEATH December 7, 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1892		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alvin Scribner			14. MOTHER'S MAIDEN NAME Helen Wight		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Margaret Caldwell 43 Concord St., Malden, Mass.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest - Nervous Shock DUE TO (b) Automobile Collision DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None of note					INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Collision Rt 3 and Rt 50 P. Geo & Md			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. #58/127/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 50 & Rt 3 Road P. Geo & Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul C. Van Natta			DATE SIGNED December 8, 1961		
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11, 1961		22c. NAME OF CEMETERY OR CREMATORY Chapman Cemetery	
22d. LOCATION (City, town, or country) (State) Gilead, Maine		23. FUNERAL DIRECTOR W.W. CHAMBERS COMPANY, Riverdale, Md.			
24a. REC'D BY REGISTRAR DATE DEC 11 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14283

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14253

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Vista		d. STREET ADDRESS Route # 50	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francois Middle Besco Last Cross				4. DATE OF DEATH Month December Day 10 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1914	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 7		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer		10b. KIND OF BUSINESS OR INDUSTRY Tile setting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Cross				14. MOTHER'S MAIDEN NAME Amanda Windear			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 1415 Harvard Street N.W.		17. INFORMANT Amanda Mason, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-42X							INTERVAL BETWEEN ONSET AND DEATH 4-42X
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED December 11, 1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Dec 14/61		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery		22d. LOCATION (City, town, or country) (State) M. D. Registrar No 229	
23. FUNERAL DIRECTOR Smith's Funeral Home		ADDRESS 2116-18th St NW		DATE Dec 14/61		24b. REGISTRAR'S SIGNATURE Walter Smith Prof.	

VS. A1SME
SM 9/6D

DEC 18 '61

Arthur L. Kross

14333

RECEIVED
NOV 19 1941

Office of the General Post Office
Washington, D. C.

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Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14254

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 1004 Merrimack Drive			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First John Middle Francis Last Dailey		4. DATE OF DEATH		Month December Day 2 Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 29, 1883	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8		11. IF UNDER 24 HRS. Hours 15 Min. 20		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY Factory			
11. BIRTHPLACE (State or foreign country) Connecticut				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 040-01-8443			
17. INFORMANT Althea D. Molitor				Address same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12/3/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-6-1961		22c. NAME OF CEMETERY OR CREMATORY FORESTVILLE CEMETERY		22d. LOCATION (City, town, or country) (State) FORESTVILLE, CONNECTICUT.	
23. FUNERAL DIRECTOR W.W. Chamber Co. Riverdale, Md				24a. REC'D BY REGISTRAR DEC 6 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1282



Prince George's

Charleston

Salisbury

Prince George's to Salisbury

Salisbury to Prince George's

Salisbury to Prince George's

Salisbury to Prince George's

Salisbury to Prince George's

Salisbury to Prince George's

Salisbury to Prince George's

Salisbury to Prince George's

1
FOR STATE
HEALTH DEPT.

Item 18 a & b,
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
File # 304 12/29/61
14285
14255
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. LENGTH OF STAY IN 1b Transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In a wooded area near Peace Cross				d. STREET ADDRESS 3417 Eastern Avenue			
3. NAME OF DECEASED (Type or print) James Owen Davis				4. DATE OF DEATH December 16 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 17, 1920	
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucking			
11. BIRTHPLACE (State or foreign country) Mitchelville, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Franklin Turner Davis				14. MOTHER'S MAIDEN NAME May S. Neff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 579-14-6756			
17. INFORMANT Mrs. Rosa M. Curtin,				Address 3417 Eastern Ave. Mt. Rainier, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Alcoholism (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED December 16, 1961			
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county) Colmar Manor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR DEC 21 '61				24b. REGISTRAR'S SIGNATURE James I. Boyd			

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935



In a wooded area near 2nd Street, City of New York

James I. Smith
17, 1930
X



Truck Driver
Trucking
Washington, D.C.

James I. Smith
17, 1930
X
Washington, D.C.

James I. Smith
17, 1930
X
Washington, D.C.

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14286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14256

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR First Middle L. Last DAY		4. DATE OF DEATH Dec. Month 4th Day 1961 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10th 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Day		14. MOTHER'S MAIDEN NAME Leeanna Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine V. Auth Address 4355- Brooks Dr. SE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial Insufficiency DUE TO (c) Hypertensive Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 wks. 4-5 yrs 8-10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1948 to Dec 4 , 19 61 , that (I) (we) lost saw the deceased alive on Dec 1 , 19 61 , and that death occurred on Dec 4 AM, from the causes and on the date stated above.			
22a. SIGNATURE Sidney W. Lowry M.D.		22b. ADDRESS 7200-MARLBORO PIKE SE	
22c. PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY M.D.		22d. ADDRESS 7200-MARLBORO PIKE SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 6 61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Sutland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Emma Bros. ADDRESS 1661- Ford Hgts Rd SE WASH. 20005		25a. REC'D BY REGISTRAR DATE DEC 6 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Thomas			

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OFFICE OF THE
SHERIFF
COUNTY OF
ALBANY
NEW YORK

1888

Prince George's

Prince George's Hospital

WATER

WATER

Bedford

XX George

P.O. No.

George

Residence 11 North 4th - Brooklyn N.Y.

June 10th 1881

DAY

John - Medical Nurse

Domestic, English

11. George's

1888

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14287

CERTIFICATE OF DEATH

14257

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 8 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 Washington 28, D. C. d. STREET ADDRESS 5134 Forrestville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha First Densmore Last December 26 19 61 Month Day Year		4. DATE OF DEATH			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Clise			14. MOTHER'S MAIDEN NAME Mary Stevenson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Rt parietal lobe 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia L. L. L. (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from December 19, 1961 to December 26, 1961 , that (I) (we) last saw the deceased alive on December 26, 1961 , and that death occurred at 7:55 a.m. from the causes and on the date stated above.					
22a. SIGNATURE Gordon W. Kelley M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED December 26, 1961	
22c. PHYSICIAN'S NAME (Type) Gordon W. Kelley, M.D.		22d. ADDRESS 6124 41st Avenue, Hyattsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/61	23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		23d. LOCATION (City, town or county) (State) Morgantown W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		24b. ADDRESS 816 H St NE		25a. REC'D BY REGISTRAR DEC 29 '61	25b. REGISTRAR'S SIGNATURE Anthony S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1884

Received of the Treasurer of the
Board of Directors of the
City of New York
the sum of \$100.00
for the year 1884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14288 CERTIFICATE OF DEATH 14258									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY in 1b 1 yr., 5 mo., & 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 478.3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS 241 Valley Ave., S.E. 478.3				
3. NAME OF DECEASED (Type or print) First Middle Last Edna O. Dickinson					4. DATE OF DEATH Month Day Year 12 28 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/1880		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry A. Sanford					14. MOTHER'S MAIDEN NAME Edmonia Wyatt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 579-07-5522		17. INFORMANT Decedent		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Acute myocardial infarction DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis								INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/13/61 to 12/28/61 that (I) (we) last saw the deceased alive on 12/27/61 and that death occurred at A.M. from the causes and on the date stated above.									
22a. SIGNATURE Moe Weiss, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/61		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1961		23c. NAME OF CEMETERY OR CREMATION Washington National Cem.			23d. LOCATION (City, town or county) (State) Suitland Maryland.		
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.					25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

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952-50-012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14289

CERTIFICATE OF DEATH

14259

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ill. b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland Edgal d. STREET ADDRESS 51X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN 11 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General				3. NAME OF DECEASED (Type or print) First Ethyl Middle L. Last Dixon			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 22, 1961	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Peer				14. MOTHER'S MAIDEN NAME Elizabeth Bradbury			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wilma D. Gilbert Address 2839 Forest Terrace, Kent Village, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute pul edema Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis Ht dis. (a), stating the underlying cause last. DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1959 to Dec 22, 1961 , that (I) ✓ saw the deceased alive on Dec 22, 1961 , and that death occurred 10:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE William D. Rosson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Prarie Township Chapel Cem.		23d. LOCATION (City, town or county) (State) Scotland, Ill.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Mascho Sons				ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR DEC 27 '61	
				25b. REGISTRAR'S SIGNATURE Clinton S. Hanna			

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James George's

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Prince George's General

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4-52-1980

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please include the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div> <div>14290</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14260</div> </div> <div> <div> <div>14290</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14260</div> </div> </div> </div> </div>											
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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b Dead on arrival		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 33 Kentland				d. STREET ADDRESS 7619 Hawthorne Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital											
3. NAME OF DECEASED (Type or print) Clara Estelle Donaldson						4. DATE OF DEATH Month December Day 2 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14 1892		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months 6 Days 9		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME XXXXXXXXXX Gee Dyson						14. MOTHER'S MAIDEN NAME XXXXXXXXXX Mary Estelle Pugh					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mary E. Hendricks						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) 442X Cerebrovascular accident Cardiovascular renal disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James I. Boyd</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 12/3/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF DEC 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Virginia			
23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md						24a. REC'D BY REGISTRAR DEC 6 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

1230

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Handwritten text at the bottom of the page, possibly a signature or date.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14291

14261

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE New York b. COUNTY St. Lawrence	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Lake	
c. LENGTH OF STAY in 1b Transit		d. STREET ADDRESS Youngs Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 50 3000 Feet West of 301		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK PAUL DUCHANO JR.		4. DATE OF DEATH Month Day Year December 30, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1924
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Mill Worker		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Fred P. Duchano		14. MOTHER'S MAIDEN NAME Elizabeth Martineau	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW II WW II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Elizabeth Duchano,		Address Star Lake, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed Chest DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Driver of an automobile that was in a collision with another car.	
20c. TIME OF INJURY Month, Day, Year 3:40 p.m. 12/30/1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road	20f. (City or town) Mitchellville, Prince Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DATE SIGNED December 30, 1961.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 4, 1962	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or country) (State) Star Lake, New York	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.		24. REC'D BY REGISTRAR Riverdale, Md.	
24b. REGISTRAR'S SIGNATURE Clairmont E. Hume		DATE Jan 4 '62	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14262											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 105 Seneca Drive						d. STREET ADDRESS 105 Seneca Drive					
3. NAME OF DECEASED (Type or print) Thelma Fern Dunlap						4. DATE OF DEATH December 30 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 29/08 55		9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government				11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Harding						14. MOTHER'S MAIDEN NAME Wilhelmina Winters					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 213-01-6594					
17. INFORMANT Mrs Marie H. James						942 Cedel Avenue Indianapolis, Ind					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22. ACTUAL SIGNATURE James I. Boyd						23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23. EXAMINER'S NAME (Type) James I. Boyd						DATE SIGNED December 30, 1961					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Jan 3, 1962		22c. NAME OF CEMETERY OR CREMATORY Washington Park East		22d. LOCATION (City, town, or country) (State) Indianapolis, Ind	
23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Maryland						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE JAN 4 '62	



14202

Prince George's

Robert Williams

101 George Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14293

CERTIFICATE OF DEATH

Reg. Dist. No. 14263

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Croom-Naylor Road		d. STREET ADDRESS Croom-Naylor Road	
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Bush Duvall		4. DATE OF DEATH Month Day Year December 1, 1961.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1873
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Dwn Home	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Bush		14. MOTHER'S MAIDEN NAME Henrietta Hodgkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Archie Duvall	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH Immed Unk		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1960, to Dec 1961, that I last saw the deceased alive on 2-3 Nov 1961, and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R B Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 12/1/61	
PHYSICIAN'S NAME (Type) Dr. Robert B. Sasscer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/61	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Croom Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE DEC 11 '61	
24b. REGISTRAR'S SIGNATURE			

14294

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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Price (in \$) 1.00

Quantity 1

Form No. 100-10

Form No. 100-10

Form No. 100-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14295				CERTIFICATE OF DEATH				14265			
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 33 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 47 d. STREET ADDRESS 3404 Shepherd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nellie C. Freeman (Young)						4. DATE OF DEATH Month December Day 1 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Laurenson						14. MOTHER'S MAIDEN NAME Ellen L. Halpin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT William S. Freeman				Address Same as #2 (Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) Adrenal Insufficiency (a), stating the underlying cause last, (c) Adeno-Carcinoma of Recto-Sigmoid colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks months										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10/28		20g. (County) 161		20h. (State) 12/1	
21. I certify that (I) (this hospital) attended the deceased from 10/28 to 12/1 , 19 61 that (I) (we) last saw the deceased alive on 12/1 , 19 61 , and that death occurred at 4:30 A.M., from the causes and on the date stated above.											
22a. SIGNATURE Dr. Saul Schwartzbach						22b. DATE SIGNED 12-1-61					
22c. PHYSICIAN'S NAME (Type) Dr. Saul Schwartzbach						22d. ADDRESS 1726 Eye St. NW, WASH. D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION (City, town or county) Colmar Manor, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 4 '61		25b. REGISTRAR'S SIGNATURE Catharine L. H...	

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James D. Jones

James D. Jones

Secretary

Mr. Jones

James D. Jones

James D. Jones

James D. Jones

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TO DEED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14297 14266											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Hyattsville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 2709 Kirkwood Place			
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year				December 18, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1909		9. AGE (In years last birthday) 52 ^{rs}		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Builder				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Roy M. Garrison				14. MOTHER'S MAIDEN NAME Minnie Peiper				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Edward Garrison			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of the liver, ascitis.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Address 5104 - 24th. Ave., Hillcrest Hgts. Md.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/19/61			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-21-1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Suitland, Md			
23. FUNERAL DIRECTOR Robert A. Mattingly				ADDRESS 131-1148 E Wash. B.D.R.				24a. REC'D BY REGISTRAR DEC 22 '61		24b. REGISTRAR'S SIGNATURE Charles S. Turner	

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1 **FOR STATE HEALTH DEPT.**

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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 14296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14267																	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia COUNTY Washington											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b DOA											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 126 34th Street S.E.											
3. NAME OF DECEASED (Type or print) Joseph E. Gayle						4. DATE OF DEATH Month December Day 17 Year 19 61											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 10, 1926		9. AGE (In years last birthday) 35 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY NAVY				11. BIRTHPLACE (State or foreign country) Richmond, Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME RUFUS LEE GAYLE						14. MOTHER'S MAIDEN NAME GRACE WRIGHT											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WORLD WAR II						16. SOCIAL SECURITY NO. 229-20-9067											
17. INFORMANT MRS GRACE SHANKLIN						Address 3326 Delaware Ave Richmond, Va											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed skull DUE TO (b) 824X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that got out of control and turned over											
20c. TIME OF INJURY 10:30 p.m. <table border="1"> <tr> <th>Month</th> <th>Day</th> <th>Year</th> </tr> <tr> <td>12</td> <td>17</td> <td>61</td> </tr> </table>						Month	Day	Year	12	17	61	20d. INJURY OCCURRED <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oxon Hill P.G. Road					
Month	Day	Year															
12	17	61															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/18/61											
EXAMINER'S NAME (Type) James I. Boyd						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec 21, 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia									
23. FUNERAL DIRECTOR W.W. Chambers, Co. Riverdale, Md.						24a. REC'D BY REGISTRAR DEC 27 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14269

14299

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges'</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6205 CARROLLTON TERRACE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SR. GARRETT RAYMOND GILLIONS</u>		4. DATE OF DEATH Month Day Year <u>Dec 1 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Thomas Gillion</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Dungan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-4054</u> Informant <u>DAUGHTER IN LAW</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO <u>5 yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Emphysema of Lungs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>Dec 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 1</u> , 19 <u>61</u> , and that death occurred at <u>1:10</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Pomeau</u> M.D. <u>3503 Penny St</u>		DATE SIGNED <u>12/1/61</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT POMEAU</u>		<u>MT Raimien M.D.</u>	
22a. BURIAL PLACE (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY	22d. LOCATION (City, town, or county) (State)
<u>Fort Lincoln Cemetery</u>	<u>Dec 4, 1961</u>	<u>Fort Lincoln Cemetery</u>	<u>Bladensburg, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>

CERTIFICATE OF DEATH

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Robert Thompson

Robert Thompson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is under 14 years of age, the death certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14300 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>FLORIDA</u> b. <u>MADISON</u> <u>6610 XXXX 23rd Avenue</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly Maryland</u>						c. LENGTH OF STAY IN 1b <u>5 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>						e. STREET ADDRESS <u>Cheverly Maryland</u>					
3. NAME OF DECEASED (Type or print) <u>Samuel S.</u>						f. DATE OF DEATH <u>12-15-61</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-17-11</u>		9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days <u>12</u> <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work or occupation if deceased was employed) <u>Sales Representative</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Madison Co. Florida</u>					
10b. KIND OF BUSINESS OR INDUSTRY <u>Sunnyland Packing Co.</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>SAMUEL T GOZA</u>						14. MOTHER'S MAIDEN NAME <u>AMANDA McLEOD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>253 10 5609</u>					
17. INFORMANT <u>Mrs. Lloyd L. Leonard</u>						Address <u>6640 23d Pl W. Hyttsville Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple internal hemorrhages</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>acute leukemia - undifferentiated</u> (c) <u>17 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Hyttsville</u>		20g. (County) <u>Prince George's</u>		20h. (State) <u>Md.</u>	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12-11-1961</u> to <u>12-15-1961</u> , that (I) <u>(two)</u> last saw the deceased alive on <u>12-15-1961</u> , and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>R.D. Bauer M.D.</u>						22b. DATE SIGNED <u>12-15-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>R.D. BAUER, M.D.</u>						22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E Pumphrey Inc</u>						25a. REC'D BY REGISTRAR <u>DEC 20 '61</u>					
ADDRESS <u>8434 Ga Ave SS Md.</u>						25b. REGISTRAR'S SIGNATURE <u>Charles S. Pumphrey</u>					

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may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash MARYLAND b. COUNTY D.C. XXXXXXXXXX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SuitlandXX Washington, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michael P GRANT				4. DATE OF DEATH Month Day Year Dec 23 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1874	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Grant				14. MOTHER'S MAIDEN NAME Mary Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James W. Grant 6105 North 23rd St Arlington, Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> After scarlet fever to case - Polio on 20 to death							INTERVAL BETWEEN ONSET AND DEATH 10 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 1961, that (I) (we) last saw the deceased alive on Dec 13 1961, and that death occurred at 10:10 PM, from the causes and on the date stated above.							
22a. SIGNATURE T O'Donovan				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) T O'Donovan	
22d. ADDRESS 2816 Ave DE				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-26-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				25a. REC'D BY REGISTRAR 131-111111 Wash D.C.		25b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO THE SECRETARY OF HEALTH
HARRISBURG, PENNSYLVANIA

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the Act relating to the regulation of the practice of medicine in this State.

The Board of Medicine has considered the same and has decided to recommend that the amendment be adopted.

I am, Sir, very respectfully,
Yours very truly,
J. H. [Signature]

TO DEPARTMENT OF HEALTH
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FOR STATE HEALTH DEPT.
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THIS CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please send the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 9/60

14302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14272

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 31 Beaver Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1425 52nd Avenue	
3. NAME OF DECEASED (Type or print) George Edward Green		4. DATE OF DEATH December 25, 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1916
9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Viola Vinnie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-2813	
17. INFORMANT Eleanor Green, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE AND SHOCK 982X DUE TO STAB WOUND OF CHEST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during an altercation	
20c. TIME OF INJURY 10:15 xx 12/25/61 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Beaver Heights P.G. (County) (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 12/26/61	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/29/61	
22c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		22d. LOCATION (City, town, or country) Maryland	
23. FUNERAL DIRECTOR Frazier's Funeral Home, Inc. 389 R.I. Ave. N. W.		24a. REC'D BY REGISTRAR DEC 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

George Green

George Green, 1812-18

George Green, 1812-18

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Item 1-12-62 Film 305
14303

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14273

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 23		
c. LENGTH OF STAY IN lb transient			d. STREET ADDRESS 2126 West Fayette Street		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) State Rt 450 -1000 ft west of Church Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Torrence Middle Walter Last Greenaway			4. DATE OF DEATH Month December Day 23 Year 19 61		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/18	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 43 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Greenaway		
14. MOTHER'S MAIDEN NAME Carrie Parm			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW II		
16. SOCIAL SECURITY NO.			17. INFORMANT George Greenaway Address 1729 Poplar Grove Baltimore 17, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 322.0 DUE TO (b) ASPIRATION OF GASTRIC CONTENTS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Acute alcoholism					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/24/61	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 12/27/61		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR Mrs. Katie R. Williams		ADDRESS 322 N. Schroeder St.		24. REC'D BY REGISTRAR DEC 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

6053

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>Anne Arundel County</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>						c. LENGTH OF STAY in 1b <u>few hrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Main parking lot, Laurel Race Track</u>											
3. NAME OF DECEASED (Type or print) <u>Roderick Lawrence Gress</u>						4. DATE OF DEATH <u>12 4 19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/16/28</u>		9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army (Sgt.)</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Gress</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes (is)</u>						16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Mrs. Monica Gress (Wife)</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning by Carbon Monoxide (suicide)</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>9773.1</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>One end of vacuum cleaner hose was hooked to exhaust pipe and the other end was inside the car.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12/4/19 61</u> Hour e.m. p.m.						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> <u>Laurel Race Track</u>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Laurel, A.A. Co., Md.</u>						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
DATE SIGNED <u>Dec. 4, 1961</u>											
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/7/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
								22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
22e. FUNERAL DIRECTOR <u>Carl B. Woberton</u>				22f. ADDRESS <u>6306 - Belau Rd, Baltimore - 6, Md.</u>				22g. REC'D BY REGISTRAR <u>DEC 12 '61</u>			
								22h. REGISTRAR'S SIGNATURE <u>E. Kinas</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14305 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14275

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxen Hill				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxen Hill			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6450 Brinkley Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JESSE G. GRIMES				4. DATE OF DEATH Month Day Year December 9, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown 1883	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Oxen Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred J. Grimes				14. MOTHER'S MAIDEN NAME Lisa Lanham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Russell E. Grimes,				Address 6450 Brinkley Rd., Oxen Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion Edemia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul C. Van Natta EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.,				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED December 9, 1961							
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1961		22c. NAME OF CEMETERY St. Barnabas Cemetery		22d. LOCATION (City, town, or country) (State) Oxen Hill Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,				24. REC'D BY REGISTRAR DEC 13 '61			
ADDRESS Riverdale, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



1302

7

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14306

Item 9 Film G305 1/22/62 iwk

14276

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights 30		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 6202 Lee Place		
3. NAME OF DECEASED (Type or print) First Bertram Middle Artra Last Groomes			4. DATE OF DEATH Month December Day 6th. Year 1961		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1880 80 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 81 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Groomes			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None			14. MOTHER'S MAIDEN NAME Isabelle Snowden		
16. SOCIAL SECURITY NO. Lucy M. Beam			17. INFORMANT Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED 12/6/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12-9-61	22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Mem. Park		22d. LOCATION (City, town, or country) (State) Highland Park Md.
23. FUNERAL DIRECTOR Henry S. Washington - Son			24a. REC'D BY REGISTRAR 4925 Alamo Ave		24b. REGISTRAR'S SIGNATURE DEC 11 '61

MEDICAL CERTIFICATION

2

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James E. Boyd

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James E. Boyd

10-9-41 The following members of Highland Park
James E. Boyd

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

2

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14277

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jericho Park		c. LENGTH OF STAY IN 1b Transit		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park 69		d. STREET ADDRESS 9739 53rd Avenue 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pennsylvania RR Track				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anne Blanche Theresa Koontz Grove				4. DATE OF DEATH December 3, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5, 1922 38 yrs.	
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Winfred Ignatius Koontz		14. MOTHER'S MAIDEN NAME Genevieve Winifred Ganon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Paul Julian Grove, same as # 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe crushing wound to body 802X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walked in front of a railroad train					
20c. TIME OF INJURY Month, Day, Year Hour, a.m., p.m. 2:30 p.m. 12/3/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Tracks		20f. (City or town) (County) (State) Jericho P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/3/61	
EXAMINER'S NAME (Type) James I. Boyd				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-7-1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or country) (State) Arlington, Virginia				23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md			
24a. REC'D BY REGISTRAR DEC 6 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



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FOR STATE
HEALTH DEPT.

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TO DEFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

14308 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14278

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Pennsylvania Philadelphia b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 2231 Spring Garden			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Gratton Last Hagerty				4. DATE OF DEATH Month December Day 23 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 19/91 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fitzpatrick				14. MOTHER'S MAIDEN NAME Ellen Diviney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Lawrence J. Hagerty				Address Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary artery disease DUE TO (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/23/61 Address (Street, city, town, or county)							
ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) James I. Boyd							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		Dec 27, 1961		Holy Cross Cemetery		Yeadon, Del. Co. Penna	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md				24. REC'D BY REGISTRAR DEC 28 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14309											
14279											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 07				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 221 West 8th., Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Alfonsus Hall				4. DATE OF DEATH December 22, 1961							
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 9th., 1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Sanitary Comm.				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Patrick Hall				14. MOTHER'S MAIDEN NAME Emma Jane Loundes				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 212-12-2973				17. INFORMANT Alice Smith Hall Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute pulmonary EDEMA 4211 DUE TO (b) CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) AORTIC INSUFFICIENCY INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/23/61			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county) Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/61		22c. NAME OF CEMETERY OR CREMATORY A.M.E. Zion.,		22d. LOCATION (City, town, or country) Fork, Md.		(State)			
23. FUNERAL DIRECTOR Robert L. Snowden				24a. REC'D BY REGISTRAR DEC 28 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14310

CERTIFICATE OF DEATH

14280

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 20 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY P.G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS Largo e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rosa A. Hanson		4. DATE OF DEATH Month Day Year December 8 19 61		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9- -82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Green				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Nathaniel Simms 1322 45th pl S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure, (b) Anteroseptal Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 18 61 to Dec. 9 61, that (I) (we) last saw the deceased alive on Dec 9 1961, and that death occurred at 12:30 from the causes and on the date stated above.							
22a. SIGNATURE Irvin M. Grassgreen M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> P.M. 22b. DATE SIGNED 12-9-61		22c. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-12-61		23c. NAME OF CEMETERY OR CREMATORY Hdy Family Com.		23d. LOCATION (City, town or county) (State) Woodmore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 4925 Duncas		25a. REC'D BY REGISTRAR DEC 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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12-12-61 Holy Family Con. Worcester, Mass.



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14312

CERTIFICATE OF DEATH

14282

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>74</u> <u>Beltsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>4714 Prince George Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E.</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 7, 1923</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired CLERK, U. S. GOVT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>				13. FATHER'S NAME <u>Thomas T. Harris</u>			
14. MOTHER'S MAIDEN NAME <u>Elsie L. King</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus coma</u> 592X DUE TO (b) <u>Hypertensive Wilson's degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic nephritis & Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u> <u>1 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> to <u>12/2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> , 19 <u>61</u> , and that death occurred at <u>7:58 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Warren</u>				22b. DATE SIGNED <u>12/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>John M. Warren, M.D.</u>				22d. ADDRESS <u>307 Prince George Street, Laurel, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u>				25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>			
ADDRESS <u>Riverdale, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1931

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Handwritten text, mostly illegible due to fading and bleed-through. Visible words include "Bureau of", "Department of", and "Washington".

Handwritten signature or initials, possibly "J. M. Wilson", written in dark ink.

W. W. CHAMBERS CO.,
Riverside, Md.
March 12-1-1931
Dear Sir:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14313

CERTIFICATE OF DEATH

14670

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>405 4th Street</u>				d. STREET ADDRESS <u>405 4th Street</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Griffith Haslip</u>				4. DATE OF DEATH <u>December 27 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIAGE STATUS <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>Sept 30 1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Accounting Office</u>		9. AGE (In years last birthday) <u>70</u> yrs.		11. BIRTHPLACE (County & State, or foreign country) <u>Savage, Md</u>	
13. FATHER'S NAME <u>James P. Haslip</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Arterio Sclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Chronic</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 27, 1961</u> , to <u>December 27, 1961</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>December 27, 1961</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u> M.D.				22b. DATE SIGNED <u>December 27, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>				22d. ADDRESS <u>Laurel, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>12/29/61</u>		<u>Meadowridge Memorial Park</u>		<u>Savage, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Caldwell</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Huns</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>JAN 2 '62</u>			

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Robert" and "Bureau" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. It is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights c. LENGTH OF STAY IN 1b 15 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Seneca Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights d. STREET ADDRESS 113 Seneca Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Leona Hearton		4. DATE OF DEATH Month Day Year December 7, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/01
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Brooks		14. MOTHER'S MAIDEN NAME Sarah E. Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Thomas J. Hearton		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Mammary carcinoma INTERVAL BETWEEN ONSET AND DEATH 6 mos 1 1/2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 61 , to 12-6 , 19 61 , that (I) (we) last saw the deceased alive on 12-4 , 19 61 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Jeanne C. Bateman M.D.		22b. DATE SIGNED 12-7-61	
22c. PHYSICIAN'S NAME (Type) Jeanne C. Bateman		22d. ADDRESS 940-25 St NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 12/8/61	23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		25a. REC'D BY REGISTRAR DEC 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14284

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 110 D Street S. E.	
3. NAME OF DECEASED (Type or print) First Middle Last Hugo Hesper		4. DATE OF DEATH Month Day Year December 11 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Library	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilhelm? Hesper		14. MOTHER'S MAIDEN NAME Aneta Egberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George A. Schwegmann		Address 3534 Porter St., N.W., Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial infarct			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 11, 1961	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL, or other disposition	22b. DATE THEREOF 12/15/61	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.	22d. LOCATION (City, town, or country) (State) Rockville, Md.
23. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C.		24a. REC'D BY REGISTRAR DEC 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

1
FOR STATE
HEALTH DEPT

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> <div> <div>14316</div> <div>14285</div> </div> </div> <div> <div>M</div> <div>X</div> <div>0</div> <div>16</div> <div>2</div> </div>												<div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Prince Georges County</div> <div>MARYLAND</div>						<div>2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)</div> <div>a. STATE</div> <div>Ohio</div> <div>b. COUNTY</div> <div>Unknown</div>																	
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Laurel</div>						<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Spencerville</div>																	
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Transit</div>						<div>d. STREET ADDRESS</div> <div>Route #1, Transit Truck Center</div>																	
<div>3. NAME OF DECEASED</div> <div>(Type)</div> <div>CLARENCE ROBERT HIRN</div>						<div>4. DATE OF DEATH</div> <div>Month</div> <div>December</div> <div>Day</div> <div>11,</div> <div>Year</div> <div>19 61.</div>																	
<div>5. SEX</div> <div>Male</div>		<div>6. COLOR OR RACE</div> <div>White</div>		<div>7. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div><input type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div>		<div>8. DATE OF BIRTH</div> <div>March 7, 1910,</div>		<div>9. AGE (In years last birthday)</div> <div>51 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div>													
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>TRUCK DRIVER</div>		<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Borden Company</div>		<div>11. BIRTHPLACE (State or foreign country)</div> <div>Ohio</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>																	
<div>13. FATHER'S NAME</div> <div>Edward C. Hirn</div>				<div>14. MOTHER'S MAIDEN NAME</div> <div>Myrtle Chapman</div>																			
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>Unknown</div>				<div>16. SOCIAL SECURITY NO.</div> <div>Unknown</div>				<div>17. INFORMANT</div> <div>Mr. Robert Hirn,</div>															
				<div>Address</div> <div>1643 Breese Road</div>				<div>Lima, Ohio</div>															
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div>																							
<div>PART I. DEATH WAS CAUSED BY:</div>																							
<div>(a) IMMEDIATE CAUSE</div> <div>Hemorrhage and shock</div>																							
<div>(b) DUE TO</div> <div>Fracture of the base of the skull, crushed chest</div>																							
<div>(c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>Compound fractures of both tibias and fibulas</div>																							
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</div>																							
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>																							
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div>				<div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)</div> <div>Pedestrian struck by an automobile</div>																			
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour</div> <div>7:20</div> <div>p.m.</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/></div>				<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Route # 1</div>															
				<div>20f. (City or town)</div> <div>Laurel</div>				<div>(County)</div> <div>P. G.</div>															
				<div>(State)</div> <div>Md</div>																			
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>																							
<div>ACTUAL SIGNATURE</div> <div>JAMES I. BOYD, M.D.</div>				<div>CHIEF MEDICAL EXAMINER</div> <div><input type="checkbox"/></div>				<div>DATE SIGNED</div> <div>December 12, 1961</div>															
<div>EXAMINER'S NAME (Type)</div> <div>JAMES I. BOYD, M.D.</div>				<div>DEPUTY MEDICAL EXAMINER</div> <div><input checked="" type="checkbox"/></div>				<div>Address (Street, city, town, or county)</div> <div>Spencerville Ohio</div>															
<div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>22b. DATE THEREOF</div> <div>12-15-1961</div>				<div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Spencerville Cem</div>															
				<div>22d. LOCATION (City, town, or country)</div> <div>Spencerville Ohio</div>																			
<div>23. FUNERAL DIRECTOR</div> <div>W. W. CHAMBERS CO.,</div>						<div>24b. REGISTRAR'S SIGNATURE</div> <div>Riverdale, Md.</div>																	
<div>24a. REC'D BY REGISTRAR</div> <div>DEC 15 '61</div>						<div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur L. Kraus</div>																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14317

CERTIFICATE OF DEATH

14286

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in lb 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Landover d. STREET ADDRESS 1 7517 Cleveland Street East Columbia Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frank H. Hooper First Middle Last				4. DATE OF DEATH December 7 19 61 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-13-03		9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Harmon Corp. Pittsburg, Pa.				11. BIRTHPLACE (County & State, or foreign country) Windom, Texas				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Hooper				14. MOTHER'S MAIDEN NAME Hattie R. Burras				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 579-123612 Beulah S. Hooper above 16. SOCIAL SECURITY NO. 579-123612	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Acute Posterior Myocardial Infarction Coronary Thrombosis, Acute Arteriosclerotic Cardiovascular Disease? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO } 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 4 , 19 61 to Dec 7 , 19 61 that (I) (we) last saw the deceased alive on Dec 6 , 19 61 , and that death occurred at 2:20 , from the causes and on the date stated above.									
22a. SIGNATURE William D. Rosson M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. William D. Rosson				22d. ADDRESS 5701 85th Ave., Carrollton, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) Colmar Manor, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Nalleys Funeral Home				ADDRESS 1214 Rainer		25a. REC'D BY REGISTRAR DEC 12 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas	

MEDICAL CERTIFICATION

1883

1883



James M. Smith

James M. Smith

James M. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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77

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14318

14287

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>68 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>65 Riverdale</u> d. STREET ADDRESS <u>5002 Queensbury Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>Mary Wilson Hopkins</u>			4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>19 61</u>										
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>Dec. 24, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Willis Wilson</u>									
14. MOTHER'S MAIDEN NAME <u>Rachel Hochlander</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>									
17. INFORMANT <u>Theodore R. Hopkins</u> Address <u>Same as #2 (Husband)</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE PULMONARY EMBOLI</u> DUE TO (b) <u>generalized atherosclerosis</u> DUE TO (c) <u>6 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		20g. (County)		20h. (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 21</u> , 19 <u>61</u> to <u>Dec 27</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Dec 27</u> , 19 <u>61</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Norman D. Comeau</u>		22b. DATE SIGNED <u>December 27, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Norman D. Comeau, M. D.</u>									
22d. ADDRESS <u>3503 Perry Street, Mt. Rainier, Maryland</u>		22e. ATTENDING PHYS. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>									
23d. LOCATION (City, town or county) <u>Washington D. C.</u>		23e. (State)											
24 FUNERAL DIRECTOR'S SIGNATURE <u>E. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>									

12312



Dec. 24, 1891

Edinburgh

Edinburgh

Edinburgh

Edinburgh

Edinburgh

Theodore N. Page, Esq. at 12 (Edinburgh)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14319

CERTIFICATE OF DEATH

14288

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 3 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Prince George's g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chapel Oaks h. STREET ADDRESS 5620 Nye Street i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Johnson First Middle Last		4. DATE OF DEATH December 30 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-12 9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) Fla 12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Eddie Dellegal		14. MOTHER'S MAIDEN NAME Charlotte O'Neal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. — 17. INFORMANT Theodore Johnson Address 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Bilateral Hydrothorax (c) Cirrhosis of the Liver			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 30, 1961, to Dec. 30, 1961, that (I) (we) last saw the deceased alive on Dec. 30, 1961, and that death occurred at 11:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Irvin M. Grassgreen M.D.		22b. DATE SIGNED 1-1-62	
22c. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN, MD		22d. ADDRESS MT. RAINIER, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) 1-6-62	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION (City, town or county) (State) Suitland Md.
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington ADDRESS 75m 4925 Doan Ave		25a. REC'D BY REGISTRAR DATE JAN 4 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VR A15 (4)
15M 9/60



10318

Edie Doherty
No. 1

Theodore Johnson
Charles B. Neal
7/14

11-11-12

CERTIFICATE OF DEATH

Reg. Dist. No. 14289

1. PLACE OF DEATH a. COUNTY Pr. George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 1956	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		d. STREET ADDRESS 8142 Old Fort Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8142 Old Fort Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Graham Jones		4. DATE OF DEATH 12 13 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-1875
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesclerk		10b. KIND OF BUSINESS OR INDUSTRY Paint Store	
11. BIRTHPLACE (State or foreign country) Wake County, N.C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Un Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-05-8356	
17. INFORMANT Elvira M. Baicar		Address 8142 Old Fort Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-Sclerotic Heart Disease & Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-24 , 19 61 , to 12/13 , 19 61 , that I last saw the deceased alive on 12/11 , 19 61 , and that death occurred at 9:00 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7519 Broadview R.S.E. Wash. 22, D.C. DATE SIGNED 12/13/61			
ACTUAL SIGNATURE Anna Coyne Todd		M.D. 7519 Broadview R.S.E. Wash. 22, D.C.	
PHYSICIAN'S NAME (Type) Anna Coyne Todd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 15 Dec 61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Bue ADDRESS 1661-40th Ave Rd Wash DC SE		24a. REC'D BY REGISTRAR DATE DEC 14 '61	
		24b. REGISTRAR'S SIGNATURE William L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED M. H. Jones		AGE 45		SEX Male		RACE White	
DATE OF DEATH 11-11-1912		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several months		PREVIOUS ILLNESS None	
NAME OF PHYSICIAN Dr. J. H. Jones		NAME OF FUNERAL HOME None		NAME OF BURIAL PLACE None		NAME OF CEMETERY None	
NAME OF REGISTRAR None		NAME OF CLERK None		NAME OF ASSISTANT CLERK None		NAME OF DEPUTY CLERK None	

may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14321

Item 9 Film 9302 12/18/61 iwk

14290

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 222 73rd St. Maryland b. COUNTY Carmody Hills Prince Geo. County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle (McInturff) Last Jones		4. DATE OF DEATH Month 12 Day 3 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-13-12
9. AGE (In years last birthday) 48 10/19 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Jewell		14. MOTHER'S MAIDEN NAME Blanche ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 58111 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Alcoholic DUE TO (c) Cirrhosis of Liver			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/24 to 12/3 19 61 that (I) (we) last saw the deceased alive on 12/3 19 61 , and that death occurred at 4:45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Gordon W. Kelley M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/1961	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DEC 11 '61	
ADDRESS 4739 Balt. Ave Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

CERTIFICATE OF DEATH

Reg. Dist. No. 14291

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. LENGTH OF STAY IN 1b <i>30yr+</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7309 Tremont Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JANE-LOCKHART - KELK</i>		4. DATE OF DEATH <i>DEC 2 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 10, 1868</i>
9. AGE (In years last birthday) <i>93</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <i>Robert George Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Mary Walker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Violet Kelk</i>		Address <i>Same as #2 (Daughter)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension secondary to Cerebral Thrombosis</i> DUE TO <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Advanced Cerebral Arteriosclerosis</i> DUE TO <i>332X</i> (c) <i>Advanced Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19 <i>50</i> , to <i>Dec</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>12-1-61</i> , 19 <i>61</i> , and that death occurred at <i>9 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.C. Etienne</i>		DATE SIGNED <i>12-2-61</i>	
PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>		ADDRESS (Street, city or town, state) <i>College Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>12/5/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DEC 4 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. King</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed on Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14323
CERTIFICATE OF DEATH
14292

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden d. STREET ADDRESS 8616 Parkway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola		4. DATE OF DEATH Month December Day 9 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME William Savoy		14. MOTHER'S MAIDEN NAME Hazel Kenner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post mortem 770.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hemolytic anemia - midbrain petechial hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5 to 12/9 , 19 61 , that (I) (we) last saw the deceased alive on 12/9 , 19 61 , and that death occurred at 1:00 M., from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Christensen M.D.		22b. DATE SIGNED 12/9/61	
22c. PHYSICIAN'S NAME (Type or print) Dr. Thomas A. Christensen		22d. ADDRESS 6905 Baltimore Avenue, College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-23-61	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Adm.		25a. REC'D BY REGISTRAR DEC 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Penn			

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10-23-01

Harvard University

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
14324									
CERTIFICATE OF DEATH									
14666									
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 63 Hyattsville Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Madison Nursing Home (5801 - 42 nd Ave.)					1 d. STREET ADDRESS 4403 Madison street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Kerr Last Kerr					4. DATE OF DEATH Dec 26, 19 61				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1866		9. AGE (In years lost birthday) yrs. 95	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager			10b. KIND OF BUSINESS OR INDUSTRY Abrasive firm		11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Enoch Kerr					14. MOTHER'S MAIDEN NAME Mary ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Madison Nursing Home Hyattsville Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420 IMMEDIATE CAUSE (a) coronary thrombosis DUE TO myocardial infarction + Hemiplegia (b) DUE TO (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 1961 to 12-26 1961, that (I) (we) last saw the deceased alive on 12-26 1961, and that death occurred at 11 P.M. from the causes and on the date stated above. 22a. SIGNATURE Leonard Hays M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Leonard Hays 22d. ADDRESS Hyattsville Md. 22b. DATE SIGNED 12-26-61 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan 4, 1962 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery 23d. LOCATION (City, town, or county) (State) Colmar Manor Md 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md. 25a. REC'D BY REGISTRAR DATE JAN 8 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes									

(M)

(5801-42 and Ave)

5801-42 and Ave

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15-10

Handwritten text, possibly a signature or name, appearing as a large, stylized scribble.

MADE IN U.S.A.

may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14293

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md				c. LENGTH OF STAY IN 1b 19 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6305 Tecumseh Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Asher Last Kidwell				4. DATE OF DEATH Month Dec Day 5 Year 1961- 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 13, 1906		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cable Splicer		10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone Co		11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry Kidwell				14. MOTHER'S MAIDEN NAME Lena Ogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 01 3319		17. INFORMANT Ruth H. Kidwell Address Berwyn Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Acute Congestive Heart Failure DUE TO (b) Phlebotomy & atherosclerosis causing (a), stating the underlying cause last. (c) Ischemic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2-3h 15yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) College Park, Md.	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 1950 to Dec 6 , that (I) (we) last saw the deceased alive on Dec 4 , 19 61 , and that death occurred at 7A M. from the causes and on the date stated above.							
22a. SIGNATURE W.L. Etienne		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/8/61		
22c. PHYSICIAN'S NAME (Type) W.L. ETIENNE		22d. ADDRESS College Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/8/61	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 11 1961	25b. REGISTRAR'S SIGNATURE Carlton S. Hume

CERTIFICATE OF DEATH

1935

INFORMED AS TO THE
CAUSE OF DEATH
BY THE
PHYSICIAN
IN THE
PRESENCE OF
THE
JURY
ON THE
DAY OF
MAY 1935
AT THE
CITY OF
BOSTON
STATE OF
MASSACHUSETTS

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

77

1

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14326

14294

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 26 East Pleasant Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1310 50th Avenue		
3. NAME OF DECEASED (Type or print) Raymond Lawrence King			4. DATE OF DEATH Month December Day 31 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1931		9. AGE (In years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Statistical		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Raymond King			14. MOTHER'S MAIDEN NAME Mary Blake		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary E. King, 1310 50th Ave., Hillside, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull and laceration of the brain (c) 821X DUE TO (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
12a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		12b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Operator of a motor cycle that got out of control			
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 12/21/61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marlboro Pike Hillside P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER		DATE SIGNED 12/31/61	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Jan. 4, 1962		22c. NAME OF CEMETERY Cedar Hill Cemetery	
22d. LOCATION (City, town, or country) Suitland, Maryland		24a. REC'D BY REGISTRAR W. W. CHAMBERS CO. Riverdale, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



Handwritten signature or text.

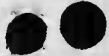
14327

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Md				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4503 Amherst Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Leroy Carl Kirsch				4. DATE OF DEATH Month Day Year Dec 7, 19 61-			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Insurance Co		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Herman Kirsch				14. MOTHER'S MAIDEN NAME Alice May Chapman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577 07 2103		17. INFORMANT Margaret Betz Kirsch College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Emphysema - General Debility							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-8 1960 to 12-7 1961, that (I) (we) last saw the deceased alive on 12-7 1961, and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Waldo B. Moyers				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers	
22d. ADDRESS 3503 Perry St. Mt. Rainier Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 11 61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

1922



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14328

CERTIFICATE OF DEATH

14296

Item 7 Film 6505 1/5/62 iwk

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN 1b 36 Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8907 Annapolis Road		d. STREET ADDRESS 8907 Annapolis Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle LANHAM Last LANHAM		4. DATE OF DEATH Month Dec. Day 22 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 12 Days 22 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Operations		10b. KIND OF BUSINESS OR INDUSTRY D. C. Goverment	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Trueman Lanham		14. MOTHER'S MAIDEN NAME Emma Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Nellie P. Lanham		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary DUE TO Myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 50 to 12-22-19 61 that (I) (we) last saw the deceased alive on Sept 30 19 61 , and that death occurred at 12-22-61 M, from the causes and on the date stated above.			
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 12-22-61	
22c. PHYSICIAN'S NAME (Type) GEORGE NARD HAYS		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/61	
23c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		23d. LOCATION (City, town, or county) (State) Lanham Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR JAN 2 '62	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE William S. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14297

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 63 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 4313 Gallatin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Guy Middle W. Last Latimer		4. DATE OF DEATH Month Dec. Day 21 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician Retired		10b. KIND OF BUSINESS OR INDUSTRY Medical Prof. ff.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James B. Latimer		14. MOTHER'S MAIDEN NAME Mary Sedwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Thelma S. Latimer same as #2 (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Measenteric Thromboses 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO Cerebral Thrombosis (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-8 19 61 , to 11-21 19 61 , that (I) (we) last saw the deceased alive on 12-21 19 61 , and that death occurred at 6 PM , from the causes and on the date stated above.			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		24. ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

13328

MAINTAINING DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR GENERAL

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FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14298

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Rainier				c. LENGTH OF STAY IN b. 48			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3149 Queens Chapel Rd. Apt. 101				d. STREET ADDRESS 3149 Queens Chapel Rd. Apt. 101			
3. NAME OF DECEASED (Type or print) GEORGE PRITCHARD LAWSON				4. DATE OF DEATH December 8, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1906	
9. AGE (In years last birthday) 55		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia	
13. FATHER'S NAME James F. Lawson				14. MOTHER'S MAIDEN NAME Maude Craddock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None				16. SOCIAL SECURITY NO. 578-05-6899			
17. INFORMANT Mrs. Eleanor T. Fussell, Lane, Alex., Va.				Address 1209 N. Quaker			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Congestion Edemia							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerostic Heart Disease							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul C. Van Natta				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.,				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) 5440 Silver Hill Rd. Parkland, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DEC 13 '61			
ADDRESS				24b. REGISTRAR'S SIGNATURE Charles E. Kline			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
14331													
14299													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 ARDMORE d. STREET ADDRESS 8813 THIRD ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BROWNIE H. LICHFORD						4. DATE OF DEATH Dec 19 1961							
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 10 1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING				11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME JAMES A. LICHFORD						14. MOTHER'S MAIDEN NAME MOLLIE WICKER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war and dates of service)						16. SOCIAL SECURITY NO. NONE						17. INFORMANT Address LLOYD H. LICHFORD SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 332X DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec 10 1961 to Dec 19 1961 , that (I) (we) last saw the deceased alive on Dec 19 1961 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.													
22a. SIGNATURE W. L. Etienne						22b. DATE SIGNED 12/20/61		22c. PHYSICIAN'S NAME (Type) W. L. ETIENNE					
22d. ADDRESS College Park, Md													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-22-1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale, Md.						25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Conrad L. Turner					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 File G304 1/2/62 jwk

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 HILLSIDE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5310 O Street</u>		d. STREET ADDRESS <u>15310 -O- STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SEVERINO LINASSI</u>		4. DATE OF DEATH Month Day Year <u>12-23-1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 25 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK LAYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>JULIA unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-07-0433</u>	
17. INFORMANT Address <u>HILLSIDE MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COR. PULMONALE</u> DUE TO (c) <u>PULMONARY EMPHYSEMA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPER NEPHROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 11, 1961</u> , to <u>Dec 23, 1961</u> , that I last saw the deceased alive on <u>Dec 22, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Tribadeau</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3112 Ala. Ave. S.E. 12-23-61</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Tribadeau</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST MARY'S CEM</u>	22d. LOCATION (City, town, or county) (State) <u>LINCOLN RD NE WASH D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.W. Chambers Co 517-11th St SE DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Phipps</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. CITY		13. COUNTY		14. STATE		15. ZIP CODE	
16. NAME OF PHYSICIAN		17. NAME OF FUNERAL HOME		18. NAME OF BURIAL PLACE		19. NAME OF CEMETERY		20. NAME OF MINISTER	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. OCCUPATION
6. PLACE OF BIRTH
7. DATE OF BIRTH
8. DATE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. PLACE OF DEATH
12. CITY
13. COUNTY
14. STATE
15. ZIP CODE
16. NAME OF PHYSICIAN
17. NAME OF FUNERAL HOME
18. NAME OF BURIAL PLACE
19. NAME OF CEMETERY
20. NAME OF MINISTER
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100. NAME OF WITNESS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

13
FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14301											
1. PLACE OF DEATH a. COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) - Edmonston			d. STREET ADDRESS 4912 49th Ave			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Alejo Middle Lopez Last Lopez Sr.					4. DATE OF DEATH Month December Day 23 , Year 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1898		9. AGE (In years and birthday) 63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Excavation		11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? U.S., A.					
13. FATHER'S NAME Alejo Lopez					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no					16. SOCIAL SECURITY NO. Helen Grace Lopez Same as # 2						
17. INFORMANT Helen Grace Lopez					Address Same as # 2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) multiple parenchymal hemorrhages of lung, multiple Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) rib fractures, intramedullary hemorrhage of the DUE TO (c) adrenal gland										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Boome of a crane fell on him										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boome of a crane fell on him								
20c. TIME OF INJURY Month, Day, Year Hour 4:00 a.m. 12/20/ 61 p.m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) James I. Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
					Address (Street, city, town, or county) 12/23/61						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 27, 1961		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Wheaton Md.					
23. FUNERAL DIRECTOR F. Gasch's Sons					ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 2 '62		24b. REGISTRAR'S SIGNATURE Charles S. Kross		

432



1
The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. It is to be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14334		Item 23 Film G303 12/22/61 mh				14302					
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SUITLAND</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5702 OFFUT DRIVE</u>						d. STREET ADDRESS <u>5702 OFFUT DR. ANDREWS ESTATES</u>					
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>LUNCEFORD</u> Last <u>LUNCEFORD</u>						4. DATE OF DEATH Month <u>DEC.</u> Day <u>12</u> Year <u>1961</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28, 1908</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Dist. of Col.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LUTHER LUNCEFORD</u>						14. MOTHER'S MAIDEN NAME <u>MAGGIE STOTHER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or date of service)		17. INFORMANT <u>FRANKLIN PENFIELD</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hepatic coma</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the Liver</u> (c) <u>unknown yet.</u> DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1960 Dec.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1961</u> to <u>12-13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>61</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>D. Ziccone Gelloni</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr ETINNE Szollosi</u>						22d. ADDRESS <u>2. PARKWAY Dr. Washington 21-X</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 16, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town or county) <u>Suitland,</u>		(State) <u>Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Lee Sam Home</u>						ADDRESS <u>300-4425 N.E. Wash.</u>		25. REC'D BY REGISTRAR <u>DEC 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

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John C. ...
June

Female ...

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May 27/18 23
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TO BE FILLED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

14335

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14303

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>618 10th Street..</u>		d. STREET ADDRESS <u>618 10th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Walter W. MACK</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Cornelius Mack</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Grace M. Mack. Item # 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>4-20-1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-31-61</u> to <u>12-31-61</u>, that (I) (we) last saw the deceased alive on <u>12-31-61</u>, and that death occurred at <u>9:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edolo Pierandrei</u>		22b. DATE SIGNED <u>12-31-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury..</u>		23d. LOCATION (City, town or county) (State) <u>Jessup, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>		25c. ADDRESS <u>Rockville, Md.</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14336

14304

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clinton Medical Center</u>		d. STREET ADDRESS <u>OPX-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Martin</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1884</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>West. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Hill</u>		14. MOTHER'S MAIDEN NAME <u>Frances Hill Akers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Howard H. Martin</u> Address <u>Hughesville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-20-0</u> DUE TO <u>Acute Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Heart Disease</u> (b) } (c) }		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>—</u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Nov. 19, 1961</u> to <u>Dec. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 21, 1961</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Max E. Feldman MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Dec. 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>MAX E. FELDMAN M.D.</u>		22d. ADDRESS <u>3800 S. Capital St. Wash. 20, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Waldorf, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt & Funeral Home, Waldorf, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 27 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14306

1. PLACE OF DEATH a. COUNTY <u>PR. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Hillcrest Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2108-KEATING ST.</u>		d. STREET ADDRESS <u>2108-KEATING ST</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>MASON</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3-1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY YARD</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John W. Robey</u>	
14. MOTHER'S MAIDEN NAME <u>ROSA MAE PILKERTON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>ERNEST M. MASON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Fibrosarcoma of Arm & Metastasis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>OCT 1961</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>27 Oct 1961</u> to <u>20 Dec 1961</u> , that (I) (we) last saw the deceased alive on <u>15 Dec 1961</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Silas M. Babin Jr</u>		22b. DATE SIGNED <u>20 Dec 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Silas M. Babin Jr</u>		22d. ADDRESS <u>1025 Vermont Ave, Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Emmons Bros.</u>		25a. REC'D BY REGISTRAR <u>1661-Cool Hope Rd SE Wash. 20 D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Finner</u>		DATE <u>DEC 22 '61</u>	

THE UNIVERSITY OF CHICAGO PRESS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14338

CERTIFICATE OF DEATH

14307

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 2800 Lancer Drive d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2800 Lancer Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Hyattsville d. STREET ADDRESS 2800 Lancer Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OSCAR WOOTEN First Middle Last MAY		4. DATE OF DEATH December 10, 19 61 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1877 yrs. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Grifton, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. May		14. MOTHER'S MAIDEN NAME Mary Wooten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. E. Murray May		Address 5506-39 Avenue, Hyattsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - Senility INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-25 , 19 58 to 12-10 , 19 61 , that (I) (we) last saw the deceased alive on 12-9 , 19 61 , and that death occurred at 10 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Waldo B. Moyer M.D.		22b. DATE SIGNED DEC 13 1961	
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyer		22d. ADDRESS 3503 Perry St. Mt. Rainier Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/12/61	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION (City, town or county) (State) PRINCE GEORGE'S MARYLAND
24. FUNERAL HOME OR SIGNATURE WARNER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR 8434 GEORGIA AVENUE SILVER SPRING, MARYLAND	
25b. REGISTRAR'S SIGNATURE		DATE DEC 13 1961	

TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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10-11-1964

ADJUTANT GENERAL'S OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14339

CERTIFICATE OF DEATH

14308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE CO. MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR. GEO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>66 RIVERDALE, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3304 LANGER DRIVE</u>			d. STREET ADDRESS <u>1500 Longfellow St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LARRY</u> First <u>LARRY</u> Middle <u>V.</u> Last <u>Mayhew</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 July 58</u>	9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>STANLEY F MAYHEW</u>			14. MOTHER'S MAIDEN NAME <u>Betty M Nichols</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Stanley F Mayhew Riverdale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO (b) <u>INANITION</u> DUE TO (c) <u>CEREBRAL PALSY - HEMOPHILIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS</u> <u>6 MOS</u> <u>LIFE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7309 RIVERDALE RD</u>	
20f. (City or town) <u>HYATTSVILLE</u>		20g. (County) <u>PRINCE GEORGE</u>		20h. (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>December 1960</u> , to <u>December 23 1961</u> , that I last saw the deceased alive on <u>21 December 1961</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Joseph F. McDonald</u>			DATE SIGNED <u>12/23/61</u>		
PHYSICIAN'S NAME (Type) <u>JOSEPH F. McDONALD MD.</u>			ADDRESS (Street, city or town, state) <u>7309 RIVERDALE RD HYATTSVILLE MD</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 26, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Bladensburg Md.</u>		22e. (State) <u>MD</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>			ADDRESS <u>Hyattsville Md.</u>		
24a. REC'D BY REGISTRAR <u>DATE 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14340

CERTIFICATE OF DEATH

14309
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 4 MONTHS 25 DAYS WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US AIR FORCE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle MICHAEL Last MC DONNELL				4. DATE OF DEATH Month DECEMBER Day 11 Year 19 61			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 JULY 1879	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER				10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME MALACHI MCDONNEL				14. MOTHER'S MAIDEN NAME CATHERINE REILLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1917-38 & 42-46 unknown			
17. INFORMANT JAMES CONSIDINE (NEPHEW)				Address 15 LOCKWOOD DRIVE OLD GREENWICH, CONN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERAL.							INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 1 YEARS 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEMIA, N.E.C., normochromic & normocytic, cause undetermined.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12 JULY , 19 61 , to 11 DECEMBER, 1961 , that I last saw the deceased alive on 11 DECEMBER , 19 61 , and that death occurred at 450A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert Kritzer				DATE SIGNED 11 DEC 1961			
PHYSICIAN'S NAME (Type) HERBERT KRITZER, CAPT USAF MC				ADDRESS (Street, city or town, state) USAF HOSP ANDREWS AFB MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-61		22c. NAME OF CEMETERY OR CREMATORY Blossburg Cemetery		22d. LOCATION (City, town, or county) (State) Blossburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers G				24a. REC'D BY REGISTRAR DATE DEC 14 '61			
ADDRESS 517-11th ST SE Wash DC				24b. REGISTRAR'S SIGNATURE Arthur L. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CENTRAL BANK OF INDIA

1948



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14310

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 20 Suitland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 3000 Parkway Terrace	
3. NAME OF DECEASED (Type or print) Sarah Theresa McGillicuddy		4. DATE OF DEATH Month December Day 02 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 March 30, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mary T. Caruso,		304 Union Ave Belleville, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of right hip (c) Due to (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell on steps			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell on steps	
20c. TIME OF INJURY Month, Day, Year 1:30 11/13/61 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Washington D.C.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/3/61	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 7, 1961	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or country) (State) ARLINGTON, VA.
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.		ADDRESS 517 11th St SE Washington, D.C.	
24a. REC'D BY REGISTRAR DEC 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



14342

CERTIFICATE OF DEATH

Reg. Dist. No. 14311

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 5 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59 West Hyattsville		d. STREET ADDRESS 6903 Calverton Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6903 Calverton Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LELIA Middle MARGUERITE Last MENDEL		4. DATE OF DEATH Month December Day 19 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Riedlieger	
14. MOTHER'S MAIDEN NAME Mary E. Heisey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 577-48-0628		INFORMANT Mauvra C. Mendel Same as #2 (daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC NEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 1 , 19 61 , to DEC 19 , 19 61 , that I last saw the deceased alive on DEC 19 , 19 61 , and that death occurred at 11 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) 4637 EASTERN AVE DATE SIGNED Dec 19 '61	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		WASH DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DEC 22 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1985

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

MARITAL STATUS

EDUCATION

DATE OF BIRTH

NAME OF DECEASED

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

SEX

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14343

14312

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale d. STREET ADDRESS 6103 Baltimore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Paul L. Messersmith		4. DATE OF DEATH Month December Day 20 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-92		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY W. S. S. C.				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Messersmith				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) WW I yes				16. SOCIAL SECURITY NO. Isabel E. Messersmith same as #2 (Wife)		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic C-V Disease (c) Hypertension & Diabetic mellitus DUE TO cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 12 hours 7-10 yrs.															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor, Md.		20g. (County) Prince George's		20h. (State) Md.					
21. I certify that (I) (this hospital) attended the deceased from 2/16, 1960 to 12/20, 1961 , that (I) (we) last saw the deceased alive on 12/19, 1961 , and that death occurred at 6:30 , from the causes and on the date stated above.															
22a. SIGNATURE Leon K. Gallin				22b. DATE SIGNED DEC 26 61				22c. PHYSICIAN'S NAME (Type) Dr. Leon Gallin				22d. ADDRESS 7206 Colesville Rd., West Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/23/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION (City, town or county) Colmar Manor, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Maryland				25a. REC'D BY REGISTRAR DEC 26 61				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

VR A15 (4)
15M 9/60

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14313											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 10 min.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 505 Main Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) DONNA K. MILLER			4. DATE OF DEATH December 8, 1961.			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH July 26, 1960			9. AGE (In years last birthday) 1 Yrs.			IF UNDER 1 YEAR Months Days 4		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY Child			11. BIRTHPLACE (State or foreign country) Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Donald Miller						14. MOTHER'S MAIDEN NAME Judith Lemke					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None						16. SOCIAL SECURITY NO. None					
17. INFORMANT Donald A. Miller,						Address 505 Main Street Laurel, Maryland.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dehydration 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis Intestinal (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Paul C. Van Natta						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
5440 Silver Hill Rd., Parkland, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED December 9, 1961.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Dec. 11, 1961			22c. NAME OF CEMETERY OR CREMATORY Cave Hill Cemetery			22d. LOCATION (City, town, or country) (State) Louisville, Kentucky.		
23. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Maryland						24a. REC'D BY REGISTRAR DEC 13 '61					
24b. REGISTRAR'S SIGNATURE Arthur S. Hance											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14345 CERTIFICATE OF DEATH 14314

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capital Heights		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 27 CAPITAL HEIGHTS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 407-61st Ave.		d. STREET ADDRESS 1 407-61st Ave -	
3. NAME OF DECEASED (Type or print) FREDERICK DEVENTURE MILLER		4. DATE OF DEATH 12/16/1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MET. POST OFFICE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASH. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK A. MILLER		14. MOTHER'S MAIDEN NAME HATTIE KIEFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Helga W. Miller 407-61st Ave Capt. Hghts. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac Failure 422.1 DUE TO (b) Anteriodisclerotic cardiovascular disease DUE TO (c) disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 12/16/1961, that (I) (we) last saw the deceased alive on 12/16/1961, and that death occurred at 4:35 PM, from the causes and on the date stated above.			
22a. SIGNATURE Peter Duus M.D.		22b. DATE SIGNED 12-16-61	
22c. PHYSICIAN'S NAME (Type) PETER DUUS		22d. ADDRESS 6124 Central Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-20-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Pk. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.W. Lees - Washington D.C.		25a. REC'D BY REGISTRAR DATE DEC 21 '61	
		25b. REGISTRAR'S SIGNATURE	



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14315

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Palmer Park (Hyattsville) 34			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7635 Muncy Road			
3. NAME OF DECEASED (Type or print) JAMES WALTER MONTGOMERY				4. DATE OF DEATH Month December Day 1 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1941	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student (Retired)		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Russell Montgomery				14. MOTHER'S MAIDEN NAME Rose Mary Lamb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Leroy S. Geer, 7635 Muncy Road, Palmer Park, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive disorder DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral palsy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH since birth	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington D.C.		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		M.D. JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 2, 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 7635 Muncy Road, Palmer Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-7-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Washington D.C.			
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.		ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DEC 7 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14316

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>26 Hillside</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5805 I Street</u>		d. STREET ADDRESS <u>15805 I Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Foyie</u> Middle <u>Elmore</u> Last <u>Masteller</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beer</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C</u>	
13. FATHER'S NAME <u>William Edgar Masteller</u>		14. MOTHER'S MAIDEN NAME <u>Luba Alice Bollinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-05-4675</u>	
17. INFORMANT <u>Minnie Dalton Masteller, son of #2</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u></u>		DATE SIGNED <u>12-28-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 30-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or country) (State) <u>Bladensburg md</u>
23. FUNERAL DIRECTOR <u>Lemmas Bros.</u>		ADDRESS <u>1661- Good Hope Rd SE WASH 20 DC</u>	
24a. REC'D BY REGISTRAR <u>JAN 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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JAMES L. JOY

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14348

CERTIFICATE OF DEATH

14317

Item 9 Film C303 12/27/61 mh

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b admn. 9-21-58			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LAUREL SANITARIUM				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
f. STREET ADDRESS 2113 34th Street S.E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma L. MURDOCK				4. DATE OF DEATH 12 15 19 61			
5. SEX Female		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1-1879	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN SHIPLEY LEMON				14. MOTHER'S MAIDEN NAME JANE SHIPLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give word or dates of service) unknown				16. SOCIAL SECURITY NO. 578-14-4844			
17. INFORMANT Hosp. RECORDS LAUREL SANITARIUM				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia (491) 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) cerebral arteriosclerosis (e), stating the underlying cause last. DUE TO with senility (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21-58 to 12-15-61 , that (I) (we) last saw the deceased alive on 12-15-61 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE John P. Kraemer M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-15-61	
22c. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				22d. ADDRESS Laurel Sanatorium, Laurel Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-18-61		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town or county) (State) SUITLAND MD	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington DC		25a. REC'D BY REGISTRAR DEC 21 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT. **M**
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **14318**

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park			c. LENGTH OF STAY IN 1b 16 Months		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #17 2d St., Cherry Hill Trailer Court			d. STREET ADDRESS 5931 15th Avenue		
3. NAME OF DECEASED (Type or print) JESSE MCCLELLAN MYERS			4. DATE OF DEATH December 9 1961.		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH August 24, 1913		
9. AGE (In years last birthday) 48			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Plumbing		
11. BIRTHPLACE (State or foreign country) Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Elijah Myers			14. MOTHER'S MAIDEN NAME Dora Lee Butler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-03-1553		
17. INFORMANT Mr. William L. Myers,			Address 103 Horners Lane Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation Shock and 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Several burned areas on body DUE TO (c) Trailer caught fire cause unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown INTERVAL BETWEEN ONSET AND DEATH Sudden D.O.A.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> Trailer Truck Fire at above address					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trailer Truck Fire at above address					
20c. TIME OF INJURY Month, Day, Year 12-9-61					
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Trailer Home					
20f. (City or town) (County) (State) Hyattsville Md Prince Georges Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul C Van Natta EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D., 5440 Silver Hill Rd., Parkway, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation					
22b. DATE THEREOF 12-12-61					
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln					
22d. LOCATION (City, town, or country) (State) Bladensburg Maryland					
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.					
24a. REC'D BY REGISTRAR DEC 13 '61					
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

1383

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14350

14319

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 25	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle Lane Last NEWBERRY		4. DATE OF DEATH Month Dec. Day 26th Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio
13. FATHER'S NAME Thomas Benton Lane		14. MOTHER'S MAIDEN NAME Lucia M. Roland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 3636-23-22	
17. INFORMANT MARIAN Sheldon		Address 3636 Greenway Dr. Wash. 23 DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis (c) 5 yr. INTERVAL BETWEEN ONSET AND DEATH 5 yr.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-30-1961 to 12-26-1961, that (I) (we) last saw the deceased alive on 12-24-1961, and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank S. Pellegrini M.D.		22b. ADDRESS 3409--Alabama Ave., S. E. Wash. 20 DC	
22c. PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI		22d. ADDRESS 3409--Alabama Ave., S. E. Wash. 20 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29-61	
23c. NAME OF CEMETERY OR CREMATORY Willwood Mem. Park		23d. LOCATION (City, town, or county) Rockford Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		25a. REC'D BY REGISTRAR 1661- Good Hope Rd SE. Wash. 20 DC	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14320

14351

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANHAM 36			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES'S GEN HOSPITAL				d. STREET ADDRESS 9212 FOWLER LANE			
3. NAME OF DECEASED (Type or print) First ALBERT Middle NICHOLS Last NICHOLS				4. DATE OF DEATH Month DEC Day 21 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 27, 1883	
9. AGE (In years lost birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY P.A. R.R.		11. BIRTHPLACE (State or foreign country) CLEARFIELD, PA.	
13. FATHER'S NAME THOMAS NICHOLS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS VIRGINIA L. CORBIN Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSES (MULTIPLE) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 19 21 Dec , 19 61 , that I last saw the deceased alive on 21 Dec , 19 61 , and that death occurred at 9:01 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas G. Maloney M.D.				ADDRESS (Street, city or town, state) 4814-71st Ave.		DATE SIGNED 22 Dec 61	
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY				ADDRESS LANDOVER HILLS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 26, 1961		22c. NAME OF CEMETERY OR CREMATORY CARLIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) ALTOONA, PENN'A.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				24a. REC'D BY REGISTRAR DATE DEC 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14352

CERTIFICATE OF DEATH

Reg. Dist. No. 14321

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 39 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Rt. #301		d. STREET ADDRESS Old Rt. #301	
3. NAME OF DECEASED (Type or print) Irene		4. DATE OF DEATH Month December Day 1 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Snowden Butler		14. MOTHER'S MAIDEN NAME Georgia A. Crandall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-36-8871	
17. INFORMANT Kenneth W. Nicholson		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July , 19 60 , to 30th Nov. 1961 , that I last saw the deceased alive on 30th , 19 61 , and that death occurred at 7:30 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE DR B. Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 12/1/61	
PHYSICIAN'S NAME (Type) Dr. Robert B. Sasscer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/61	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home		24a. REC'D BY REGISTRAR DEC 11 '61	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur A. Hume	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE [Faint text]</p>		<p>PLACE [Faint text]</p>	



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FOR STATE
HEALTH DEPT. **M**
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14353

14322

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne 03X-2		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 2 Hrs.			c. LENGTH OF STAY IN 1b 2 Hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 330 1st Avenue		
3. NAME OF DECEASED (Type or print) First THELMA Middle Brinn Last NINER			4. DATE OF DEATH Month December Day 9 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 November 8 , 1921 40 yrs.	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Practical		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME James Brinn		14. MOTHER'S MAIDEN NAME Alice Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Thez R. Kendall, Pasadena, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fractured Ribs DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Collision Driver of Auto struck Tractor Trail			
20c. TIME OF INJURY Month, Day, Year Hour 7:00 p.m. 12/9/ 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Route #1 Cherry Lane at Oakcrest	
20f. (City or town) (County) (State) Prince Georges Cty., Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul C. Van Natta		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 10, 1961	
EXAMINER'S NAME (Type) 5440 Silver Hill Rd. Parkland, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE THEREOF 12/13/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22e. ADDRESS Ambrize Inc. 1328 Sulphur Spring Rd.		24. REC'D BY REGISTRAR / 24b. REGISTRAR'S SIGNATURE DEC 15 '61 Charles S. Kraus	

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OFFICE OF THE SECRETARY OF THE ARMY

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CERTIFICATE OF DEATH

Reg. Dist. No.

14323

14354

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASH. DC.</u> b. COUNTY <u>47X.3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>4 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>812 Jefferson ST. WASH. DC.</u>		d. STREET ADDRESS <u>812 Jefferson Street APT. 11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 La Salle Rd. Hyattsville Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOLA</u> Middle Last <u>BETZEL</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 6, 1885</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Lemuel Owen</u>				14. MOTHER'S MAIDEN NAME <u>LAURA High Field</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		INFORMANT Address <u>Sister M. Agnes Patricia O'Leary, Carroll Manor</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis of the coronaries</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the abdomen.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 9,</u> 19 <u>61</u> , to <u>Dec 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec. 29,</u> 19 <u>61</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter K. Angevine</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6308-13th St NW, 12/30/61</u>			
PHYSICIAN'S NAME (Type) <u>WALTER K. ANGEVINE, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Henia Co. Wash 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Walter S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1884



Blank lines for recording death information.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14355
CERTIFICATE OF DEATH
14324

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pv. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reserdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>39 hours</u>				d. STREET ADDRESS <u>2252 Hannon St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beland Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mauda Matilda Offutt</u>				4. DATE OF DEATH <u>Dec 17, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-82</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Christopher Wagoner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Shryok</u>			
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Hosp. record (son)</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac asthma</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Senile myocarditis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>several months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov-30, 1961</u> , to <u>Dec 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 16, 1961</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John N. Andrews</u>				22b. DATE SIGNED <u>12-17-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				22d. ADDRESS <u>6601 Greenfield Rd Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/19/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.A. Hewes Co.</u>				25a. REC'D BY REGISTRAR <u>Wesley S. Hewes</u>			
25b. REGISTRAR'S SIGNATURE <u>Wesley S. Hewes</u>				DATE <u>DEC 20 '61</u>			

14321

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Christophersen, Raymond

no

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14356
CERTIFICATE OF DEATH
14325

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>512118 Kirkwood West Hyattsville, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Hospital 4408 Queenbury Rd.</u>				d. STREET ADDRESS <u>1 2718 Kirkwood</u>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>It.</u> Last <u>Ornstein</u>				4. DATE OF DEATH Month <u>12</u> Day <u>-2</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unk Heyder</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma rectosigmoid colon</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>61</u> , to <u>12/2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>61</u> , and that death occurred at <u>3:35</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl W. Graeff</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>				22d. ADDRESS <u>2716 Kirkwood Rd. W. Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Memorial</u>		23d. LOCATION (City, town or county) _____ (State) _____ <u>Elmhurst Pa.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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14357

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14326

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
c. LENGTH OF STAY IN b 15 hrs		d. STREET ADDRESS 6123 Parkwood Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		4. DATE OF DEATH Dec 6 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 May 1888	
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, MECHANIC DE. TRANSIT CO		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM OSBORNE		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) World War I		16. SOCIAL SECURITY NO. 578-10-7811	
17. INFORMANT Margaret Osborne		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac Vascular Dis. (c) Prev. Cerebral Vascular accidents 1955-1957		INTERVAL BETWEEN ONSET AND DEATH 1 day ? 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5 1961 to 12/6 1961, that (I) (we) last saw the deceased alive on 12/6 1961, and that death occurred at 12:20AM on the causes and on the date stated above.			
22a. SIGNATURE Gordon W. Kelley M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Riverdale, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 11 '61	

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It is hereby certified that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of ... State of ...

Witness my hand and the seal of the County of ... at the City of ... this ... day of ... 19...

County Clerk

Notary Public

My Comm. Expires

Subscribed and sworn to before me this ... day of ... 19...

Notary Public

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14327

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY MARIE PARKE				4. DATE OF DEATH Month Day Year December 27, 1961.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1911	
9. AGE (in years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		11. BIRTHPLACE (State or foreign country) Ramey Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Kramp				14. MOTHER'S MAIDEN NAME Martha Strike			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 217-34-2445			
17. INFORMANT Mr. John T. Parke,				Address 6004 Longfellow St., East Riverdale Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Rheumatic Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED December 27, 1961.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				24. REC'D BY REGISTRAR Jan 2 '62			
ADDRESS Mt. Rainier Maryland				25. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14359

CERTIFICATE OF DEATH

14329

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b 9 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier		47	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3810 32nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel		First A.		Middle Peckham		Last December 7 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Robert Haskins		14. MOTHER'S MAIDEN NAME Elizabeth Virginia French					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis - Basilar artery 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Hypertensive Cardio Vascular Disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 6 wks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11/28 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/28 19 61 to 12/7 19 61 , that (I) (we) last saw the deceased alive on 12/7 19 61 , and that death occurred at 4:40 from the causes and on the date stated above							
22a. SIGNATURE Gordon W. Kelley		M.D. A.M.		22b. DATE SIGNED DEC 11 '61			
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mt. Rainier Md		25a. REC'D BY REGISTRAR DATE DEC 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. French	

(M)

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278-12-3613
William H. Graham
Attorney at Law
Washington, D.C.
278-12-3613

12/1/61
Mr. J. Edgar Hoover
U.S. Department of Justice
Washington, D.C.

delay is necessary,
director. Page
for your files.
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VS. AISME
SM 9/60

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Dunbar Phelps		4. DATE OF DEATH Month December Day 22 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 12, 1895	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William W. Phelps		14. MOTHER'S MAIDEN NAME Capitola Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number and dates of service) Yes WW#1		16. SOCIAL SECURITY NO. 577-01-1000	
17. INFORMANT Spencer Phelps		Address 7125 Allison MD Landover Hills.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Crushed chest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right arm		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of automobile that was struck by another car	
20c. TIME OF INJURY Month, Day, Year 6:15 p.m. 12/22 19 61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) On Road		20f. (City or town) (County) (State) Bowie P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 12/23/61	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/61	
22c. NAME OF CEMETERY OR CHURCH Holy Trinity Church		22d. LOCATION (City, town, or country) (State) Collington, Md.	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE DEC 27 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1323

Finance Board

2.2.44

Finance Board - General Hospital

Chairman: Mr. J. H. ...

Members: Mr. J. H. ...

Secretary: Mr. J. H. ...

William W. ...

Charles J. ...

3.1.45 - 3.1.46

Finance Board

General Hospital

Finance Board

General Hospital

Finance Board

2.2.44

Finance Board

General Hospital

Finance Board

General Hospital

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14331

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges Gen. Hospital				d. STREET ADDRESS Well's Corner- Route 4		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES EDWARD RIDGELY				4. DATE OF DEATH Dec. 11 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1909		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Francis Ridgely				14. MOTHER'S MAIDEN NAME Estella Seltzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 10 9130		17. INFORMANT Address Marie W. Ridgely, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO (b) SEVERE, OCCLUSIVE ARTERIOSCLEROSIS, CORONARY ARTERY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 11, 1961	
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-61		22c. NAME OF CEMETERY OR CREMATORY MT CARMEL		22d. LOCATION (City, town, or country) (State) UPPER MARLBORO, MD.	
23. FUNERAL DIRECTOR The Hunt Funeral Home, WALDORF, MD.				24a. REC'D BY REGISTRAR DEC 15 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

1931

James I. Boyd

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14332

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home, Inc.</u>		d. STREET ADDRESS <u>7312 Justin Street</u>	
3. NAME OF DECEASED (Type or print) <u>MARCELLA</u> First Middle Last		4. DATE OF DEATH <u>12-22-1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kloyd Barbour</u>		14. MOTHER'S MAIDEN NAME <u>? unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bessie Richards</u> Address <u>7312 Justin St. Dist Hgts.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY 10 YRS DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DUDDENAL ULCER, ANEMIA, HYPOPLASTIC TYPE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12/18/1961</u> , and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7200 Marlboro Pike SE</u> DATE SIGNED <u>Dec 27 '61</u>			
ACTUAL SIGNATURE <u>Kelvin L. Minchin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Land</u>		22b. DATE THEREOF <u>Dec 26</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1601 K St NW Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

14363

CERTIFICATE OF DEATH

Reg. Dist. No. 14333

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Suitland District Heights, 28</u>	
c. LENGTH OF STAY IN <u>4 1/2 years</u>		d. STREET ADDRESS <u>7202 Foster St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> → First <u>Minerva</u> → Middle <u>ROBERTSON</u> Last		4. DATE OF DEATH <u>December 3, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>		13. FATHER'S NAME <u>William Bruce Robertson</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Maria Robinson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <u>1</u>		INFORMANT <u>Louise R. Campbell (niece)</u> Address <u>7202 Foster St. District Heights, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> 42010 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>20 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>5 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>June 17, 1957</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 17, 1957, to December 3, 1961, that I last saw the deceased alive on December 21, 1961, and that death occurred at 10:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Walcutt W. Gibson</u>	M.D. <u>4340 St. Barnabas Road Dec. 3, 1961</u>
PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u>	<u>Washington 21, D.C.</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE OF BURIAL <u>12/5/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Broad Creek Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruthie Gros Upper Marlboro, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

PROBIO

12/3/51
RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14334											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D.C. b. COUNTY ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor.						c. LENGTH OF STAY IN 1b 4 Weeks					
3. NAME OF DECEASED (Type or print) Julia E. Rush						4. DATE OF DEATH Month Dec. Day 20 Year 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 22, 1890		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (County & State, or foreign country) NEW YORK - STATE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Owen F. Sweeney						14. MOTHER'S MARRIED NAME ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. ?					
17. INFORMANT Dr. Robert C. Rush						Address Washington D.C. 5827-Utah Ave N.W.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (c) 1 year DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 11/22/1961				20g. (County) 12/20/1961				20h. (State) 11:40			
21. I certify that (I) (the hospital) attended the deceased from 11/18/1961 to 11/22/1961 , that (I) (we) last saw the deceased alive on 11/18/1961 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Collins						22b. DATE 12-20-1961					
22c. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.						22d. ADDRESS 322- H. St. N.E.- Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-23-61				23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY			
23d. LOCATION (City, town or county) WASHINGTON, D.C.				23e. REC'D BY REGISTRAR DEC 27 '61				23f. REGISTRAR'S SIGNATURE William S. Turner			
24. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol-2224 W. 1st. Ave N.W.											

4321

1995

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Generalized Anxiety Disorder

US/501481

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130181

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100-100-25

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14365

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14335

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1524-2	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 601 Sligo Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) June Lois Ryan		4. DATE OF DEATH Month December 1 Day Year 1961	
5. SEX Female	6. COLOR White XXXXXX	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 5, 1924 37
9. AGE (In years last birthday) 37		10. UNDER 1 YEAR Months Days	10. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Richard Dulyea		14. MOTHER'S MAIDEN NAME Gertrude Ellen Krome	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 386-20-1574	
17. INFORMANT 2009 Quinn Street William Lewis Dulyea, Silver Spring, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute carbon monoxide poisoning DUE TO (b) 89/1.5 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a car that had a defective exhaust	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:15 p.m. 12/1/ 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Street		20f. (City or town) Bladensburg P.G. (County) Md (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/1/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-1961	
22c. NAME OF CEMETERY OR CREMATORY White Chapel Mem. Garden		22d. LOCATION (City, town, or country) Muskegon, Michigan (State)	
23. FUNERAL DIRECTOR W.W. Chambers Co		24a. REC'D BY REGISTRAR DEC 5 '61	
ADDRESS Riverdale, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1935

1935



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "January", "February", and "March" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14366

Item 8 Film G303

12/27/61 mh

14336

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

29 hrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE b. COUNTY

Maryland

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

39 Philadelphia Ave

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Julia

Marie

Schaff

4. DATE OF DEATH

December 17 19 61

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

April 6, 1915

9. AGE (In years last birthday)

46 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waitress

10b. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Moses

14. MOTHER'S MAIDEN NAME

Hannah Joseph

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

7015 18th Ave
Louis W. Moses West Hyattsville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Intracranial hemorrhage

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Due to a fall

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

Fell an head struck the tiled floor

20c. TIME OF INJURY

12:30 a.m.

Month, Day, Year

Dec 16/61

20d. INJURY OCCURRED

While work ☐ Not While work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Motel Room

20f. (City or town)

College Park

(County)

P.G.

(State)

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

EXAMINER'S NAME (Type)

James I. Boyd

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

December 18, 1961

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec 20, 1961

22c. NAME OF CEMETERY OR CREMATORY

Date of Heaven Cemetery

22d. LOCATION (City, town, or county)

Montgomery County, Maryland

23. FUNERAL DIRECTOR

ADDRESS

Arthur Walters, 254 Carroll St NW Wash D.C.

24a. REC'D BY REGISTRAR

DEC 21 '61

24b. REGISTRAR'S SIGNATURE

Arthur E. Hines

TO DEATH BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14337

FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the District Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>An. Geo</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westchester</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westchester</u>	
c. LENGTH OF STAY in 1b <u>4 years</u>		d. STREET ADDRESS <u>6108 Westchester Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6108 Westchester Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Leroy</u> Last <u>Schnake</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1909</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAM Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Schnake</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>NORMA JEAN MARSH</u>		Address <u>4276 N. Holly Road Oxon Hill MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HANGING</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in hallway at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-13-1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Westchester P.S. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-14-61</u>	
Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 19-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>
23. FUNERAL DIRECTOR <u>Simmons Bros. 1661 W. 1st St. SE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14368
CERTIFICATE OF DEATH
14338

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor		d. STREET ADDRESS 3405 40th Place	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sally PRINCE Schneck				4. DATE OF DEATH Month Day Year Dec. 11 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Sept. 1883	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas M. Guage		14. MOTHER'S MAIDEN NAME Annie Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Annie Morris 3405-40th St. N. Colmar Manor Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Broncho pneumonia (c) Antero sclerotic Ht. fr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/9 to 12/11, 1961 that (I) (we) last saw the deceased alive on 12/11, 1961, and that death occurred at 1:40 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Gordon W. Kelley				22b. DATE 12/14/61		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL-CREMAATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-61		23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		23d. LOCATION (City, town or county) (State) Hartsville South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr.				25a. REC'D BY REGISTRAR DEC 14 '61		25b. REGISTRAR'S SIGNATURE C. S. Thomas	



14382

James G. Givens

July 17

James G. Givens

July 17

James G. Givens

July 17

James G. Givens

July 17

James G. Givens

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James G. Givens

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James G. Givens

July 17

1
FOR STATE
HEALTH DEPT.
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2
TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please file this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14339

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 2821 7th Street N.E.			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Elizabeth Schoenbauer				4. DATE OF DEATH Month Day Year December 14 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MEX Feb 2, 1893 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Lawrence				14. MOTHER'S MAIDEN NAME Julia Kenny			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				17. INFORMANT Address 2710 Webster Joseph Charles Schoenbauer Mt Rainier, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary occlusion (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic for last 14 years						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED December 14, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 19-18-1961		22c. NAME OF CEMETERY OR CREMATORY Fork Lincoln	
				22d. LOCATION (City, town, or country) (State) Prince George Co Md			
23. FUNERAL DIRECTOR Robert A. Mattingly				ADDRESS 131-11 St Wash. D.C.		24a. REC'D BY REGISTRAR DEC 18 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1938

Director of Education

Education

Prince George's County, Maryland

Virginia - Elizabeth County

May 1938

Director of Education

John Henry

Local Office, Prince George's County, Maryland

County Office

County Office

Director of Education

May 1938

Director of Education

May 1938

Director of Education

Director of Education

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14340

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN lb 9 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US AIR FORCE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 6014 SILVER HILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle SCHONRANK Last SCHONRANK		4. DATE OF DEATH Month DECEMBER Day 12 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 NOVEMBER 1880
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE ENGINEER	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME AUGUST SCHONRANK		14. MOTHER'S MAIDEN NAME ANNA (MAIDEN NAME UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT RONALD LOUGHREY (NEPHEW)		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ADEMA 420.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) CHRONIC PULMONARY DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 20 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 DECEMBER 19 61 to 12 DECEMBER 19 61 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12 DECEMBER 19 61 and that death occurred at 625 A M, from the causes and on the date stated above.			
22a. SIGNATURE Isaac Weiszer		22b. DATE SIGNED 12 DECEMBER 1961	
22c. PHYSICIAN'S NAME (Type) ISAAC WEISZER CAPT USAF MC		22d. ADDRESS USAF HOSP ANDREWS AFB MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 15-61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City, town, or county) (State) Suitland md
24. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS		25a. REC'D BY REGISTRAR DEC 14 '61	25b. REGISTRAR'S SIGNATURE William L. Turner

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UNITED STATES

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

James W. Brown

1110 ...

James W. Brown
1110 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14371

14342

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Laurel, Md. b. COUNTY Pr. Geo. Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 1036 Ward St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Joseph James Scott		4. DATE OF DEATH Month Day Year 12-5-61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Owned store	11. BIRTHPLACE (County & State, or foreign country) Missouri
13. FATHER'S NAME Scott, James		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 434-1	
17. INFORMANT Mrs L C Marley, Laurel Md		Address Laurel Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 434-1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Deep Vein Thrombosis DUE TO (c) Pain		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Laurel, Pr. Geo. Co., Md
21. I certify that (I) (this hospital) attended the deceased from 12/5/61 to 12/5/61 , that (I) (we) last saw the deceased alive on 12/5/61 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert C. Wingfield		22b. DATE SIGNED DEC 11 '61	
22c. PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD		22d. ADDRESS Laurel, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/7/61	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City, town or county) (State) Burtonsville Md
24. FUNERAL DIRECTOR'S SIGNATURE William J. Walden		25. REGISTRAR'S SIGNATURE William J. Walden	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MAY 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14372
CERTIFICATE OF DEATH
14343

1. PLACE OF DEATH e. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchelville d. STREET ADDRESS Route 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Rebecca First Sellman Last		4. DATE OF DEATH December 11 19 61 Month December Day 11 Year 19 61				
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-96	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPL. (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hall		14. MOTHER'S MAIDEN NAME Hall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Hall		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) L.H. Bronchopneumonia (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/10 , 1961 to 12/11 , 1961, that (I) (we) last saw the deceased alive on 12/11 , 1961, and that death occurred at 10:20 from the causes and on the date stated above.						
22a. SIGNATURE Gordon W. Kelley		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. A.M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-17-61		23c. NAME OF CEMETERY OR CREMATORY Union Chapel		23d. LOCATION (City, town or county) Bristol
24. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS Anna M.		25a. REC'D BY REGISTRAR DEC 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14667

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN 1b 21 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 31		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oron E. Sherbert, Jr.		4. DATE OF DEATH Month December Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1917
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min. 44	IF UNDER 24 HRS. Months 44 Days 44 Hours 44 Min. 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foremen		10b. KIND OF BUSINESS OR INDUSTRY County Bd. of Education	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oron E. Sherbert, Sr.		14. MOTHER'S MAIDEN NAME Eva Gertrude Crandell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 578-10-7096	
17. INFORMANT Mrs. Thelma Agnes Sherbert-Same as Item #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Ischemia DUE TO (c) Coronary artery heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 13 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) natural causes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Dec. 18, 1961 to Dec 31, 1961 , that I last saw the deceased alive on Dec 31, 1961 , and that death occurred at 3:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul C Van Natta		ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE, Washington 2806	
PHYSICIAN'S NAME (Type) PAUL C VAN NATTA		DATE SIGNED Dec 31/1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/62	
22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JAN 11 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 111

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DR. RICHARD H. BARNETT

DR. RICHARD H. BARNETT

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Prince George

Barlyland

East Village

2011 7th Place

Prince George's General Hospital

2409

May 24, 1880

Franklin Co., Tenn.

Anna Mary Miller

John Thompson

none

Handwritten: George Thompson
Catherine Thompson

Hagerstown, Md.

Rest Haven Cemetery

12-29-01

burial

Scott F. Minnich & Son, Hagerstown, Md.

TO DETECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14375 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14345

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier		d. STREET ADDRESS 3110 Upshur Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3110 Upshur Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Tipton Smith (Holbrook)				4. DATE OF DEATH Month December Day 23, Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1880	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alfred Taylor				14. MOTHER'S MAIDEN NAME Hannah Tipton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. None			
17. INFORMANT 4309 Russell Ave., Hazel Mamie Smith Mt. Rainier, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 12/23/61			
22b. DATE THEREOF 12/26/61				22c. NAME OF CEMETERY OR CREMATORY George Washington			
22d. LOCATION (City, town, or country) Hyattsville, Md.							
23. FUNERAL DIRECTOR Francis Gasch's Sons				24a. REC'D BY REGISTRAR DEC 27 '61			
ADDRESS Hyattsville, Maryland				24b. REGISTRAR'S SIGNATURE Charles S. Kline			

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Francis G. Goss

W. H. Goss

W. H. Goss

W. H. Goss

W. H. Goss

W. H. Goss

W. H. Goss

W. H. Goss

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W. H. Goss

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George Washington

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Francis Goss's Sons

Francis Goss's Sons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

* prosthesis; chronic brain syndrome.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14376									
14346									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE D. C. b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington				
c. LENGTH OF STAY IN lb 30 days					d. STREET ADDRESS 2009 Franklin St., NE				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last James - Smith					4. DATE OF DEATH 12 13 19 61				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 6/25/75				
9. AGE (In years last birthday) 86 yrs.					10. IF UNDER 1 YEAR Months Days 12 13				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard					10b. KIND OF BUSINESS OR INDUSTRY Retired (government)				
11. BIRTHPLACE (County & State, or foreign country) N.C.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Henry Harris Smith					14. MOTHER'S MAIDEN NAME Betty Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Unknown				
17. INFORMANT Decedent and Mrs. Susie H. Payne					Address 424 West Stonewall St. Charlotte 6, N.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Dehydration, malnutrition and toxicity 7 15X DUE TO (b) Multiple infected decubitus ulcers Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Generalized arteriosclerosis; pulmonary emphysema; osteoporosis; fracture neck, rt., femur, open reduction & replacement of femoral head by metallic* 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 11/13/1961 to 12/13/1961, that (I) (we) last saw the deceased alive on 12/13/1961, and that death occurred at P.M. from the causes and on the date stated above. 22a. SIGNATURE Moe Weiss M.D. 22b. DATE SIGNED 12/13/61 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 17, '61		23c. NAME OF CEMETERY OR CREMATORY National Harmony		23d. LOCATION (City, town or county) (State) Prince Georges' County, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co 3015-17th St. N.E. Philip J. Kay 9437 3015-17th St. N.E. Robert L. P. Rhines, Director					25a. REC'D BY REGISTRAR DATE DEC 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Rhines		

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Prince George

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and file 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital												2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS P.O. Box 4403 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) Oscar				First Middle Last Smith				4. DATE OF DEATH December 20 19 61				5. SEX Male				6. COLOR OR RACE Colored				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5-21-1884				9. AGE (In years last birthday) 77 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed								10b. KIND OF BUSINESS OR INDUSTRY None								11. BIRTHPLACE (County & State, or foreign country) South Carolina								12. CITIZEN OF WHAT COUNTRY? U.S. A.															
13. FATHER'S NAME John Smith								14. MOTHER'S MAIDEN NAME Charlotte Rhinehart								15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. None								17. INFORMANT Ellie Smith - Brandywine, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insuff. DUE TO (c) Diabetes Mellitus												INTERVAL BETWEEN ONSET AND DEATH 12ds 3yrs ?																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																											
21. I certify that (I) (this hospital) attended the deceased from 12/10 to 12/20, 19 61 that (I) (we) last saw the deceased alive on 12/20, 19 61, and that death occurred at 6:25 PM, from the causes and on the date stated above.												22a. SIGNATURE Gordon W. Kelley M.D. 22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley												ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED											
22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/23/61				23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION (City, town or county) Washington (State) D. C.																											
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines, Inc.								ADDRESS 3015 12th St. N.E.								25a. REC'D BY REGISTRAR DATE DEC 27 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Hines																			

VR A15 (4)
15M 9/60

12/27

Unemployed

John Smith

None

U.S. A.

South Carolina

Charlotte Rhinehart

U.S. A.

None

U.S. A.

U.S. A.

U.S. A.

U.S. A.

U.S. A.

Handwritten signature

12/27

Handwritten signature

12/27

Unemployed

John Smith

None

U.S. A.

CERTIFICATE OF DEATH

Reg. Dist. No. 14348

14378

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA, VA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASALLE RD</u>				d. STREET ADDRESS <u>803 MANOR RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>C</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 5 - 1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON-DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ELMER GARDNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY CONNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>			
INFORMANT <u>Sister Agnes Patricia Carroll Manor</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma right lung.</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>61</u> , to <u>Dec. 10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>61</u> , and that death occurred at <u>9:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Kelly</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>12/10/61</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY</u>				M.D. <u>6480 N. H. Ave., Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Phares</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14308

CERTIFICATE OF DEATH

13378

(M)

10441

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14379

14349

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
c. LENGTH OF STAY IN b. 32 days		d. STREET ADDRESS Doves Apt. #12	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theresa M. Smith	First Middle Last	4. DATE OF DEATH Dec 6 19 61	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1916
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Perrie		14. MOTHER'S MAIDEN NAME Sarah Windsor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Marie Lawson Hardwood, Md. Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Left Cor Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic Ht. Ht. (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephrosclerosis Advanced		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/11 19 61 to 12/6 19 61 that (I) (we) last saw the deceased alive on 12/6 19 61, and that death occurred at 2:25AM from the causes and on the date stated above.		22a. SIGNATURE Gordon W. Kelley M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Va. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE DEC 11 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	



Francis Gash's Sons Hyattsville, Md.

June 12, 1901

Arlington National

Arlington, Va.

Mr. George W. Smith

With this letter, I enclose

12/5

12/5

12/5

My kind regards to all

Very truly yours,
Francis Gash's Sons

Francis Gash's Sons, Hyattsville, Md.

Thomas Harris

Baron Windsor

Own home

Maryland

12/5

July 12, 1901

12/5

12/5

12/5

12/5

Francis Gash's Sons, Hyattsville, Md.

Baron Windsor

12/5

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12/5

12/5

12/5

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14380

CERTIFICATE OF DEATH

14350

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PG</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5501 43rd Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Jesse William Sprowls</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>61</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/17/87</u>		9. AGE (In years last birthday) <u>74</u> yrs. <table border="1" style="width: 100%; font-size: 0.8em;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>University of Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Stockdale Sprowls</u>				14. MOTHER'S MAIDEN NAME <u>Cora Williams</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give we or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Glenn Sprowls</u> Address Washington, Pa. RFD 6									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of Lung</u>								INTERVAL BETWEEN ONSET AND DEATH 									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12-1</u> to <u>12-13</u> , 19 <u>61</u> , that (I) <u>(we)</u> saw the deceased alive on <u>12-13</u> , 19 <u>61</u> , and that death occurred at <u>4:35 PM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-15-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Hyattsville, Md.</u>				22d. ADDRESS <u>Hyattsville, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City, town or county) <u>Hyattsville,</u> (State) <u>Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
14381 CERTIFICATE OF DEATH 14351														
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4 d. STREET ADDRESS 1217 Hanover Street									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. Prince George's General Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Ida Middle I. Last Stallings					4. DATE OF DEATH Month December Day 4 Year 19 61									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-96		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Maryland				
13. FATHER'S NAME William John Boswell					14. MOTHER'S MAIDEN NAME Isabelle Gardner					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Address Mrs. Hilda Peakie-1224-44 Pl S.E. Washington				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 WEEK SEVERAL YEARS				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from AUGUST 12/3 , 19 61 , to 12/3 , 19 61 , that (I) (we) last saw the deceased alive on 12/3 , 19 61 , and that death occurred 11:55 from the causes and on the date stated above.														
22a. SIGNATURE James Duke M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12/4/61						
22c. PHYSICIAN'S NAME (Type) Dr. Clarence J. Duke					22d. ADDRESS 6607 Riverdale Road, Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-7-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland						
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm J. Jackson & Sons - North Co., Balto Md.					25a. REC'D BY REGISTRAR DEC 6 '61		25b. REGISTRAR'S SIGNATURE Charles S. Pinner							



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14382

CERTIFICATE OF DEATH

14352

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 32 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hosp.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Prince Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Lanham d. STREET ADDRESS 6006 Princess Gardens Pkwy. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLENN ELMORE STANCLIFF				4. DATE OF DEATH 12 31 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-91	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Botanist				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Windfield Stancliff				14. MOTHER'S MAIDEN NAME Flora Crandell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs. Gertrude B. Stancliff Same as #2 (Wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Coronary vascular atherosclerosis DUE TO (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 11-29-61 , 19....., to 12-31-61 , 19....., that (I) (we) last saw the deceased alive on 12-31-61 , 19....., and that death occurred at 3:45 PM the causes and on the date stated above. 22a. SIGNATURE A. Deitz M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. Aaron Deitz 22d. ADDRESS 4314 Gallatin St., Hyattsville, Md. 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS 4314 Gallatin St., Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 5 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH
necessary, If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE				Maryland		b. COUNTY		Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				Palmer Park 34			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prince George's General Hospital		d. STREET ADDRESS				8035 Barlow Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Terry		Lee		Steinat		December		13		19		61			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 28, 1961		yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		None		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Franklin George Steinat		Margaret Ann Libby									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		No		None		Franklin George Steinat, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		490X		Bilateral lobular pneumonia		DUE TO				CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED		December 13, 1961			
ACTUAL SIGNATURE		James I. Boyd		M.D.											
EXAMINER'S NAME (Type)		James I. Boyd		Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)		BURIAL		12-15-1961		Arlington National	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE		DEC 18 '61		O. L. Kline			
W. W. Chambers & Co		Baltimore, Md.													

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14354

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Fairmont Heights			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1010 59th., Avenue			
3. NAME OF DECEASED (Type or print) Louis Stewart				4. DATE OF DEATH December 25, 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 100	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Carol Stewart				Address same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) DUE TO (c) 932.0							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Left in an unheated house			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 12/25/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Fairmont Heights P.G. (County) Md (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 12/25/61			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-30-61				22b. DATE THEREOF 12-30-61			
22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony				22d. LOCATION (City, town, or country) Highland Pk. Md (State)			
23. FUNERAL DIRECTOR Henry S. Washington & Sons				24a. REC'D BY REGISTRAR 4925 Penn			
24b. REGISTRAR'S SIGNATURE				DATE JAN 2 '62			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 11, 12, 13 & 14 Film G305 1/10/62 14355

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived in Institutions; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Elm Street	
3. NAME OF DECEASED (Type or print) First Willie Middle Stewart Last Stewart		4. DATE OF DEATH Month Dec Day 28 Year 19 61	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1893
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 3 Days 10	IF UNDER 24 HRS. Hours 10 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stevenson		14. MOTHER'S MAIDEN NAME Mary Gross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number or date of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Glomerulonephritis Renal Failure DUE TO (b) Hypertensive Arteriosclerotic Cardio Vas. Dis DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/7 1961 to 12/28 1961 , that (I) (we) last saw the deceased alive on 12/28 1961 , and that death occurred at 5:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Gordon W. Keller		22b. DATE SIGNED 12/28 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Keller		22d. ADDRESS 6124 41st Avenue, Hyattsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	1/4/1962	Arlington National	Arlington, Virginia
24 FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co.		25a. REC'D BY REGISTRAR JAN 4 1962	
ADDRESS 1432 You Street, N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13382



13382

Handwritten signature
J. W. ...

13382

Street Service Co. 1418 1/2 Street, N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14386

CERTIFICATE OF DEATH

14356

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN TB <u>18 1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park 69</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>9741 Wichita Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marlin A. Stibitz</u>		4. DATE OF DEATH <u>12 12 19 61</u>		5. SEX <u>m</u>		6. COLOR OR RACE <u>wh</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-28</u>		9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office manager Gen. Accep. Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Roy E Stibitz</u>		14. MOTHER'S MAIDEN NAME <u>MAE E Rhoads</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-20-5876</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 421.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Severe aortic insufficiency and aortic valve disease 14 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1961</u> to <u>Dec. 12, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Dec. 11, 1961</u> , and that death occurred at <u>5:29 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>R. H. Sandstrom</u> M.D. <u>12-12-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.H. SANDSTROM</u>		22d. ADDRESS <u>10202 Lanston Lane Silver Spring Md</u>		22e. REC'D BY REGISTRAR <u>DEC 18 '61</u>		22f. REGISTRAR'S SIGNATURE <u>Charles L. Fennell</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		23d. LOCATION (City, town or county) (State) <u>Herndon, Fairfax Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		24a. ADDRESS <u>Mt. Rainier Md.</u>		24b. DATE <u>DEC 18 '61</u>		24c. REGISTRAR'S SIGNATURE <u>Charles L. Fennell</u>	

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R. H. SANDSTROM

Office Manager for Army Corp. Gen. A. E. Rhoads
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185 N. 1st St. S. W. Wash. D.C.

10-13-43 33

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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14387
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14357

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 40 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3715 Shepherd St.							
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD EDWARD SUPPLIE JR		4. DATE OF DEATH Month Day Year Dec. 11 19 61									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 16, 1932		9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Washington Sanitary Comm		11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Harold E Supplee		14. MOTHER'S MAIDEN NAME Frances Bragg									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Navy		16. SOCIAL SECURITY NO.		17. INFORMANT Harold E Supplee		Address Colmar Manor, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Insufficiency DUE TO 163X Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic Carcinoma DUE TO (c) metastatic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 1 Hour 1 month 1 month									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from OCT 1961 to Dec 1961 , that (I) (we) last saw the deceased alive on Dec 11 1961 , and that death occurred at 930 PM from the causes and on the date stated above.											
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED 12/12/61		22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Miller, M.D.		22d. ADDRESS 3824-34 St. Mt. Palmer Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.		25a. REC'D BY REGISTRAR DATE DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Howard					

CERTIFICATE OF DEATH

11381

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible] MARITAL STATUS: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MEDICAL ATTENDANT: [illegible]

DECEASED'S SIGNATURE: [illegible] WITNESSES' SIGNATURES: [illegible]

REGISTRAR'S SIGNATURE: [illegible] OFFICIAL SEAL: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

REGISTRAR'S NAME: [illegible] OFFICIAL SEAL: [illegible]

DECEASED'S SIGNATURE: [illegible] WITNESSES' SIGNATURES: [illegible]

REGISTRAR'S SIGNATURE: [illegible] OFFICIAL SEAL: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

REGISTRAR'S NAME: [illegible] OFFICIAL SEAL: [illegible]

DECEASED'S SIGNATURE: [illegible] WITNESSES' SIGNATURES: [illegible]

REGISTRAR'S SIGNATURE: [illegible] OFFICIAL SEAL: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

REGISTRAR'S NAME: [illegible] OFFICIAL SEAL: [illegible]

DECEASED'S SIGNATURE: [illegible] WITNESSES' SIGNATURES: [illegible]

REGISTRAR'S SIGNATURE: [illegible] OFFICIAL SEAL: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

REGISTRAR'S NAME: [illegible] OFFICIAL SEAL: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14388

CERTIFICATE OF DEATH

Item 13 Film 9303 12/27/61 mh

14358

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY prince Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS P.O. Box e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Swann, Rita Mae		4. DATE OF DEATH Month Dec. Day 17 Year 19 61	
5. SEX Female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 6 months 6
11. BIRTHPLACE (County & State, or foreign country) Pri. Geo. Gen. Hosp.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Swann		14. OTHER'S MAIDEN NAME Patty Polly Baden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father Upper Marlboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) Pneumonia Meningitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-15-61 , 19 61 , to 12-17-61 19 61 , that (I) (we) last saw the deceased alive on 12-17-61 19 61 , and that death occurred at 10:35 PM on the causes and on the date stated above.			
22a. SIGNATURE Gordon W. Kelley M.D.		22b. DATE SIGNED 12/18/61	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley Med./Staff		22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Burial 12-20-61	23c. NAME OF CEMETERY OR CREMATORY Mosses	23d. LOCATION (City, town or county) (State) Anne Arundel Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Sellers		25a. REC'D BY REGISTRAR DEC 22 61	
ADDRESS 4339 Hunt Pl., N.E.		25b. REGISTRAR'S SIGNATURE Arthur A. Harris	

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11322

Upper Harbor

King's College, Hong Kong

St. John's, N.S.W.

18-10-41

St. John's, N.S.W.

St. John's, N.S.W.

St. John's, N.S.W.

Penetration through

12-12-41

10-12-41

14-11-41

Penetration through
12-12-41
10-12-41
14-11-41

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14389

CERTIFICATE OF DEATH

14359

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. STREET ADDRESS 5701 Addison Chapel Road			
3. NAME OF DECEASED (Type or print) NORRIS W SYDNOR				4. DATE OF DEATH DEC 28 1961			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Aug 1915	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13. FATHER'S NAME Henry Sydnor				14. MOTHER'S MAIDEN NAME Ethel Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —			
17. INFORMANT Betty E. Sydnor				Address 5701 Addison Ch. Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure							2 hours
420 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							2 hours
(b) Occlusion of Anterior Descending Coronary Artery							2 hours
(c) Coronary Arteriosclerotic Heart Disease							unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 DEC 1961 , to 28 DEC 1961 , that (I) (we) last saw the deceased alive on 28 DEC 1961 , and that death occurred at 7:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. R. Richard Compton M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. R. Richard Compton M.D.				22d. ADDRESS 612 Main St. Laurel., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-2-62		23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony		23d. LOCATION (City, town or county) (State) Highland PK. Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons				ADDRESS 4925 Deane NE		25a. REC'D BY REGISTRAR JAN 2 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WOKRIS W

ETHEL MILLER

HENRY SYDNEY

Betty E. Sydney

NO

23000

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14390
14360
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUITLAND</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 SUITLAND</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5115-LOGAN ST SE</i>		d. STREET ADDRESS <i>5115-LOGAN ST SE</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>E.</i> Last <i>Taylor</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>24</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 11-1873</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John J. Cordle</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hill Cordle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>William H. Taylor</i>		Address <i>5115-LOGAN ST SE. SUITLAND MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive cardiac failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Broncho pneumonia</i> DUE TO (c) <i>Senile - General Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>10 days</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none of note</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Natural Causes</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>—</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>Dec 21</i> , 19 <i>61</i> , to <i>Dec 24</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Dec 23</i> , 19 <i>61</i> , and that death occurred at <i>9:55</i> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>PAUL C VAN Natta</i>		22b. DATE SIGNED <i>Dec 24 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>PAUL C VAN Natta</i>		22d. ADDRESS <i>5440 SILVER HILL RD WASHINGTON 28 DC.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 28-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Emporia Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Emporia Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel B. Hall - 9414 1/2 W. 1st St. Wash DC</i>		25a. REC'D BY REGISTRAR <i>—</i> DATE <i>DEC 27 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>—</i>			

James H. Taylor

St. Louis

2112 - 1839 - 27 28

L. Taylor

E. Taylor

Aug 11 - 1872 - 22

Female white

Housewife

James H. Taylor

John T. Corbett

Elizabeth H. Taylor

William H. Taylor

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14392

CERTIFICATE OF DEATH

14362

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 6104 Jay Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Thomas		4. DATE OF DEATH Month Dec. Day 10 Year 19 61		5. SEX Male			
6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-18-11			
9. AGE (In years last birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Papco			
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank W Thomas			
14. MOTHER'S MAIDEN NAME CARRIO G Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 2			
17. INFORMANT Raymond Thomas		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left intracerebral hemorrhage (b) hypertensive Cardiovascular disease (c) 443X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 12/8		20g. (County) 19 61		20h. (State) 12/10			
21. I certify that (I) (this hospital) attended the deceased from 12/10 19 61 to 12/10 19 61 that (I) (we) last saw the deceased alive on 12/10 19 61 and that death occurred at 12:05 AM the causes and on the date stated above.							
22a. SIGNATURE Gordon W Kelley		22b. DATE SIGNED 12/10/61		22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley			
22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) 12-15-61		23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat		23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington		25a. REC'D BY REGISTRAR DATE DEC 15 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Lundy 4/12/41 4200 4422 Lundy Is

Albino

hours after death. TO BE ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14393						14363					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Prince Georges</i> MARYLAND						a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince Georges</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>74 MUMKIRK</i>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <i>1 Conaway Rd.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED						4. DATE OF DEATH					
First Middle Last <i>WALTER E. THOMAS</i>						Month Day Year <i>December 23, 1961</i>					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>Brown</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-25-07</i>		9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wash. Suburban Am. Laborer</i>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Henry Thomas</i>						14. MOTHER'S MAIDEN NAME <i>Minnie Brenner</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <i>Matthie Thomas Mumkirk Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Ca of body of pancreas.</i> (c) DUE TO (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Dec. 20, 1961, to Dec. 23, 1961</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 20, 1961</i> , to <i>Dec. 23, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 23, 1961</i> , and that death occurred at <i>12:35 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Gordon W. Kelley</i> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>Dr. G. Kelley</i>						22d. ADDRESS <i>6124 41st Ave Hyattsville Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>12-28-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Queens Chapel</i>		23d. LOCATION (City, town or county) (State) <i>Mumkirk Maryland</i>			
24 FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Washington</i>						ADDRESS <i>4925 Deane</i>		25a. REC'D BY REGISTRAR <i>DEC 29 '61</i>		25b. REGISTRAR'S SIGNATURE <i>James S. Thomas</i>	

VR A15 (4)
15M 9/60

1
The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14394

Item 9 Film G305 1/12/62 iwk

14668

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 70 College Park		d. STREET ADDRESS 5008 Pierce Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Thompson		4. DATE OF DEATH Month Day Year Dec. 18 19 61		5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. AGE (In years last birthday) 71 70 yrs.		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Oakcrest, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Robinson		14. MOTHER'S NAME Elizabeth Hebron		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-4 1961, to 12/18 1961 that (I) (we) last saw the deceased alive on 12/18 1961, and that death occurred at 2:20AM from the causes and on the date stated above.									
22a. SIGNATURE Gordon W. Kelley M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley		22d. ADDRESS 6124 41st Avenue Laurel, Md.		6124 41st Avenue Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-61		23c. NAME OF CEMETERY OR CREMATORY Saint Mary's Cem.		23d. LOCATION (City, town or county) Laurel, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Joynes		ADDRESS 116 Mass. Ave. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE JAN 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



14395

CERTIFICATE OF DEATH

Reg. Dist. No. 14364

1. PLACE OF DEATH o. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Oxon Hill (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5430 Oxon Hill Rd S.E.</u>				d. STREET ADDRESS <u>5430 Oxon Hill Rd S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Thompson</u>				4. DATE OF DEATH <u>12 - 22 19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (State or foreign country) <u>Oxon Hill, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Walter Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-38-3338</u>			
				17. INFORMANT <u>Ruth Thompson</u> Address <u>5430 Oxon Hill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocardial Degeneration</u> DUE TO (c) <u>Right Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> <u>9 months</u> <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-23, 1961</u> , to <u>12-22, 1961</u> , that I last saw the deceased alive on <u>12-15, 1961</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.				ADDRESS (Street, city or town, state) <u>7519 B Roadview Rd S.E.</u> DATE SIGNED <u>Wash. 22, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd</u>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>12/27/1961</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Turner</u> ADDRESS <u>2500 Nichols Ave S.E.</u>				24a. REC'D BY REGISTRAR <u>DEC 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14365

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5303 Forestville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Rudolph Elmer Torguson			4. DATE OF DEATH December 1, 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1912	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist		10b. KIND OF BUSINESS OR INDUSTRY Sign painting		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Gustave C. Torguson		
14. MOTHER'S MAIDEN NAME Thalia B. Thorsen			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give branch and dates of service) Yes WW II		
16. SOCIAL SECURITY NO. 545-18-1146			17. INFORMANT Ida Sylvia Torguson, same as # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatic necrosis 816X DUE TO Trauma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) collision Driver of an automobile that was in an head on			
20c. TIME OF INJURY 8:43 p.m. 11/22/61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 4	20f. (City or town) Forestville	(County) P.G.	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/2/61	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-5-61	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl	22d. LOCATION (City, town, or country) Arlington	(State) Va	
23. FUNERAL DIRECTOR Summers Bros		ADDRESS 1661-16th Ave NW SE WASH DC		24a. REC'D BY REGISTRAR DEC 4 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

... (faint text) ...

CERTIFICATE OF DEATH

Reg. Dist. No. 14366

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>4 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brandywine-Waldorf Clinic</u>		d. STREET ADDRESS <u>Hughesville</u>	
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Toye</u> Last <u>Toye</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1961</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>14</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DeSales B. Toye</u>		14. MOTHER'S MAIDEN NAME <u>EVA. I. Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>DeSales B. Toye</u>		Address <u>Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>circumflex ligament</u> DUE TO <u>S.O.I.X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bleeding</u> DUE TO <u>Bleeding</u> (c) <u>Bleeding</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>307</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>12:30 AM</u> <u>12</u> <u>30</u> <u>AM</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 10</u> , 19 <u>61</u> , to <u>Dec 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>61</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Brandywine, Md.</u> DATE SIGNED <u>Dec 14</u>			
ACTUAL SIGNATURE <u>Richard B. Johnson</u>		M.D. <u>Brandywine, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard B. Johnson</u>		<u>Brandywine, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt & Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT CO. HEADQUARTERS—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14398

14367

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived; If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Charles Volentine		4. DATE OF DEATH December 25, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1917
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		10b. KIND OF BUSINESS OR INDUSTRY Agricultural	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Opie Kenneth Volentine		14. MOTHER'S MAIDEN NAME Nora McCoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Mildred Lucille Volentine, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CARDIAC FAILURE			
DUE TO (b) HEMORRHAGE, ATHEROMATOUS PLAQUE, CORONARY ARTERY			
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 12/25/61	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-61	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or country) (State) Blacksburg Maryland	
23. FUNERAL DIRECTOR W.W. Chambers Co		24. REC'D BY REGISTRAR DEC 29 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

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FOR STATE
HEALTH DEPT.
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TO DIRECTOR: This certificate should be executed within 24 hours after death. If any of the information is necessary, please consult the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14399 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14368

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George County Jail		d. STREET ADDRESS 6107 Forest Road	
3. NAME OF DECEASED (Type or print) HAROLD LEE WALKER		4. DATE OF DEATH December 10, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader Ret. Gov't Printing		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME William E. Walker		14. MOTHER'S MAIDEN NAME Corrine Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by Hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 9776X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chirrod of Liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11:50 a.m. 12/9/ 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County Jail		20f. (City or town) Upper Marlboro, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE PAUL C. VAN NATTA EXAMINER'S NAME (Type) 5440 Silver Hill Rd. Parkland, Md.		DATE SIGNED December 10, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-61	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) Arlington Virginia	
23. FUNERAL DIRECTOR W. W. Chambers & Co. Ave. Riverdale, Md.		24a. REC'D BY REGISTRAR DEC 13 '61	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14401

14369

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrestville d. STREET ADDRESS 8334 Leona Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Linwood L. Ward		4. DATE OF DEATH Month December Day 4 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-11		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 4 Days 19		IF UNDER 24 HRS. Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Cab Company				11. BIRTHPLACE (County & State, or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Lindsey Ward								14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----				17. INFORMANT Doris E. Ward Address Same 2									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis left 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic Hb dis. (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus														INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bladensburg, Md.		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 12-2 , 19 61 , to 12/4 , 19 61 , that (I) (we) last saw the deceased alive on 12/4 , 19 61 , and that death occurred at 9:50 , from the causes and on the date stated above.																	
22a. SIGNATURE Gordon W. Kelley M.D.								ATTENDING PHYS. <input type="checkbox"/> M.D. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley								22d. ADDRESS 6124 41st Avenue., Hyattsville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7 Dec. 1961		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION (City, town or county) Bladensburg, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE J W LEE ADDRESS 3004 ST. N.E.								25a. REC'D BY REGISTRAR DATE DEC 7, '61				25b. REGISTRAR'S SIGNATURE Charles S. Kraus					

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If additional copies are necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14403

CERTIFICATE OF DEATH

14371

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> c. LENGTH OF STAY in 1b <i>18 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince Georges General</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Upper Marlboro</i> d. STREET ADDRESS <i>1 RFD Box 4038</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Michael Wedge</i>		4. DATE OF DEATH Month Day Year <i>12-24-1961</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Brown</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 12, 1961</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unk.</i>	
14. MOTHER'S MAIDEN NAME <i>Katherine Wedge</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mother</i> Address <i>Sams as # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Gastro Enteritis</i> <i>77200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Dehydration</i> DUE TO (c) <i>Severe Malnutrition</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>3 days (?)</i> <i>3 days?</i> <i>3 weeks</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	22f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 6, 1961</i> , to <i>Dec 24, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 24, 1961</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Gordon W. Kelley</i> M.D.		22b. DATE SIGNED <i>Dec. 26, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Gordon W. Kelley, M. D.</i>		22d. ADDRESS <i>6124 41st Avenue, Hyattsville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1/4/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Washington D. C.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>F, Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 5 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14404

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14372

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seitland Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Seitland Nursing Home 4450 White Hall St.</u>		d. STREET ADDRESS <u>3712 Woodridge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ida + Helga Werner</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(Unknown) Simmon</u>		14. MOTHER'S MAIDEN NAME <u>Emma Reinle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Mrs. Marion Schmitz Balt., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>acute cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH, <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 19, 1957</u> to <u>Dec 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>12-24-1961</u> , and that death occurred at <u>4 pm</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Peter Duus</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>PETER DUUS</u>		22d. ADDRESS <u>6124 Central Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>30 Dec. '61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druidridge Cem. Balt. Md.</u>		23d. LOCATION (City, town or county) (State) <u>Capitol Heights 27 Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 300-4th St. N.E.D.C</u>		25a. REC'D BY REGISTRAR <u>DEC 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

VR A15 (4)
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CERTIFICATE OF DEATH

14405

14372

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 70 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9137 Baltimore Ave., College Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel First Whitehead Middle Whitehead Last		4. DATE OF DEATH Dec. 16, 1961 Month Dec. Day 16, Year 19 61	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-80 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker 10b. KIND OF BUSINESS OR INDUSTRY Wood work 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Whitehead 14. MOTHER'S MAIDEN NAME Sarah MacDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO 16. SOCIAL SECURITY NO. 518-03-6247 17. INFORMANT Mrs. Florence Satterlee Address 9137 Baltimore College Pk. Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse and fever 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebrovascular accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1961 to Dec. 16, 1961 , that (I) (we) saw the deceased alive on Dec 16, 1961 , and that death occurred at 2:28 PM , from the causes and on the date stated above 22a. SIGNATURE Ronald E Krum MD M.D. 22b. DATE SIGNED 12-16-61 22c. PHYSICIAN'S NAME (Type) Ronald E. Krum, M.D. 22d. ADDRESS 4408 Queensbury Road, Riverdale, Md.	
23a. BURIAL CREMATION Burial 23b. DATE THEREOF Dec. 19, 1961 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery 23d. LOCATION (City, town or county) (State) Beltsville, Maryland.		24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md. 25a. REC'D BY REGISTRAR DEC 20 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Krum	

EVAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

CO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14406

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14374

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5403-24th Avenue		d. STREET ADDRESS 15403-24th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clara O. Hilberg		4. DATE OF DEATH 12-24-1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1878
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Howard City, Mich.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Olaf B. Hilberg		14. MOTHER'S MAIDEN NAME Lena Olson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Laura C. Carr Address address above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior wall MI (heart disease) 360.0 DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10-1958 to 12-24-1961, that (I) (we) last saw the deceased alive on 12-24-1961, and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE David S. Gordon		22b. DATE 12-24-61	
22c. PHYSICIAN'S NAME (Type) DAVID S. GORDON		22d. ADDRESS 5721-23rd Parkway, S.E. Washington 21, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/61	
23c. NAME OF CEMETERY OR CREMATORY Ambler Cemetery		23d. LOCATION (City, town, or county) (State) Ambler, Michigan	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		25a. REGISTRAR'S SIGNATURE	
ADDRESS Mt. Rainier		25b. REGISTRAR'S SIGNATURE	
DATE DEC 28 '61			

Reg. Dist. No. 1375

14407

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN lb. <u>6 months</u>		d. STREET ADDRESS <u>407 Pershing Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6403 Ager Road - Nursing home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Arthur</u> Middle <u>Winkler</u> Last		4. DATE OF DEATH <u>Dec. - 10</u> Month <u>10</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Months	Days
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		Hours	Min.
11. BIRTHPLACE (State or foreign country) <u>Geo. Wash. Univ. Hosp. Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. - A.</u>	
13. FATHER'S NAME <u>Herman M. Winkler</u>		14. MOTHER'S MAIDEN NAME <u>Jean M. Buttrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Herman M. Winkler</u>		Address <u>407 Pershing Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>7 5 2 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Terminal term chlophrenia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>breth on 1 day</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 6, 1961</u> to <u>Dec 10, 1961</u> , that I last saw the deceased alive on <u>Dec 9, 1961</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D. <u>College Park, Maryland</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>12/10/61</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS A. CHRISTENSEN COLLEGE PARK, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/22/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D. DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

11407

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14408

CERTIFICATE OF DEATH

14376

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Fairmont Heights d. STREET ADDRESS 706 - 59th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George A. Wood		4. DATE OF DEATH Month December Day 18 Year 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-82
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 19 Min. 61	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11b. KIND OF BUSINESS OR INDUSTRY D.C. Government Wash. D.C.	
12. BIRTHPLACE (County & State, or foreign country) Unknown		13. CITIZEN OF WHAT COUNTRY? Unknown	
14. FATHER'S NAME Moses Wood		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. Walter R. Wood	
18. INFORMANT Same as 2D		Address Some as 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Bilateral hydronephrosis and hydronephrosis (b) Carcinomatosis DUE TO Carcinoma of the Prostate Gland (c) Carcinoma of the Prostate Gland PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH months months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/24 , 19 61 , to 12/18 , 19 61 that (I) (we) last saw the deceased alive on 12/18 , 19 61 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Louis B. Bachrach M.D.		22b. DATE SIGNED 12/29/61	
22c. PHYSICIAN'S NAME (Type) LOUIS B. BACHRACH M.D.		22d. ADDRESS 915-19 ST. N.W., WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-23-61		23b. DATE THEREOF 12-23-61	
23c. NAME OF CEMETERY OR CREMATORY Nat Harmony		23d. LOCATION (City, town or county) (State) Highland Pk Md	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washburn		25a. REC'D BY REGISTRAR DEC 27 '61	
ADDRESS 4925 Alameda Ave 712		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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12402

James Smith

James Smith

Retired

D. C. Smith

Mc

James Smith

Corporal of the Lincoln State

James Smith

James Smith

1941

1941

1941

James B. Smith

James B. Smith

James B. Smith

James B. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14409

CERTIFICATE OF DEATH

14327

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY PG			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt,			
				d. STREET ADDRESS 8 M Laurel Hill Rd			
3. NAME OF DECEASED (Type or print) George				4. DATE OF DEATH 12/7/1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/81	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert A. Wyly				14. MOTHER'S MAIDEN NAME Ella. Hatchet			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Effie Wyly.				Address #8. M. Laurel Hill Rd Greenbelt. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) Cerebral Vascular Disease - Hemiplegia							INTERVAL BETWEEN ONSET AND DEATH 7 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/2 to 12/7 , 19 61 , that (I) (we) last saw the deceased alive on 12/7 , 19 61 , and that death occurred at 9:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE Gordon W. Kelley M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley				22d. ADDRESS 6124 41st Avenue, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12.11.61		23c. NAME OF CEMETERY OR CREMATORY Nat. Memo. Park		23d. LOCATION (City, town or county) (State) Falls Church. Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home 300.4th st N E. Wash. D				25a. REC'D BY REGISTRAR DEC 13 1961		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1892

1892



Handwritten signature or name, possibly "J. W. ...".

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

14410

14378

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211- Oneida Way				d. STREET ADDRESS 211- Oneida Way			
3. NAME OF DECEASED (Type or print) DANIEL F. ZUBKO				4. DATE OF DEATH Month Dec. Day 12th Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11th 1913	
9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Dept.				10b. KIND OF BUSINESS OR INDUSTRY Photo. Intelligence Pa.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Michael Zubko				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WM # 2.			
17. INFORMANT Margaret M. Zubko (Wife) Same as #2.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 289.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Periarteritis Nodosa DUE TO (c) Collagen disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1959 , 19, to 12-12 , 19 61 , that (I) (we) last saw the deceased alive on 12-12 , 19 61 , and that death occurred at 12 M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Etienne Szokosi				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. ETIENNE Szokosi				22d. ADDRESS 24 PARKWAY Dr, Washington 24-DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 15- 61			
23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Simon Brothers				25a. REC'D BY REGISTRAR 1801- Gd. Hope Rd SE Washington DC			
25b. REGISTRAR'S SIGNATURE William S. Thomas				DATE DEC 14 '61			

MEDICAL CERTIFICATION

11111

(M)

Prince George's

Forest Heights

311-0414 NY

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White

White

Very Good

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